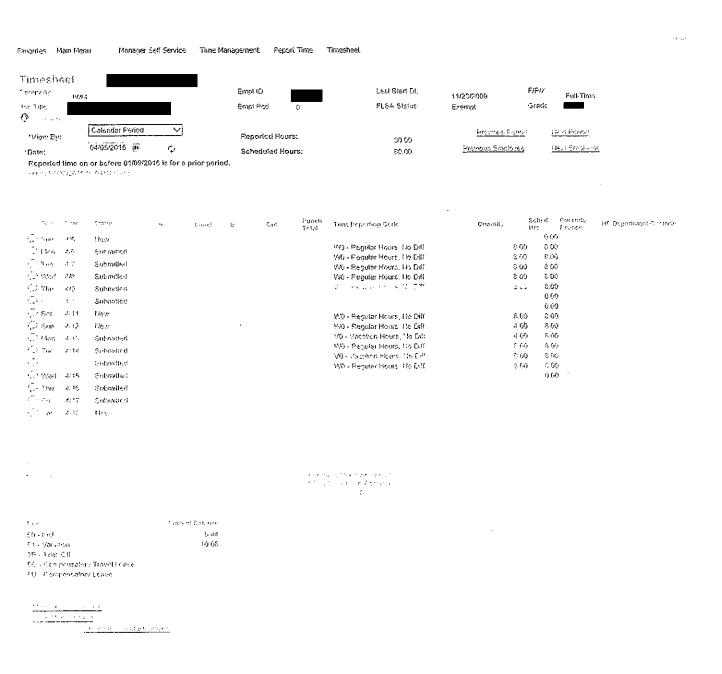


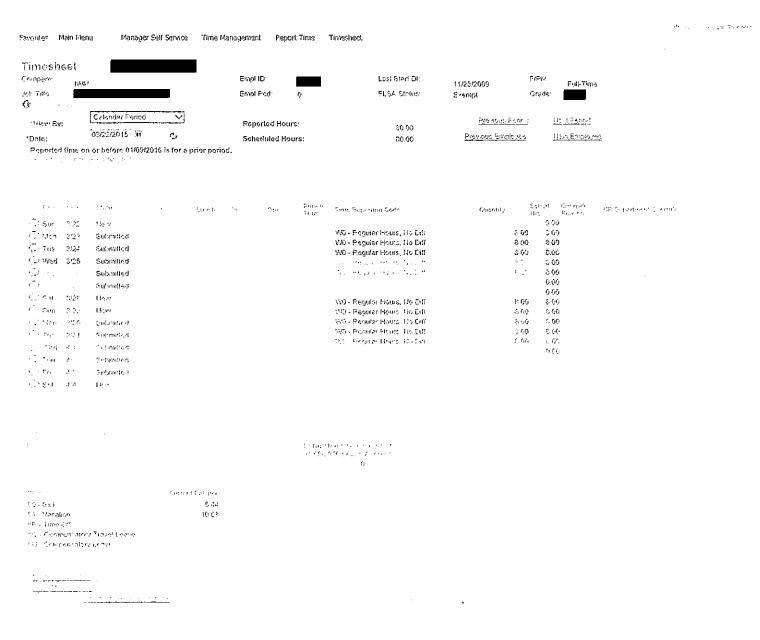
		Request	for Leav	e or Approv	ed Abse	nce
Request for Leave or Approved Absel  1. Name (Last, first, middle)  2.					Employee or Social Security Number	
Z.					Employee of Coolai Coolaity Number	
3. Organization		<u></u>				
P&C						
4.	Т	ype of Leave/A	heence			C Combination of the state of t
Check appropriate box(es) and	hov(es) and Doto Time			5. Family and Medical Leave		
enter date and time below)	From	То	From	To	Total Hours	If annual leave, sick leave, or leave without pay will be used under the Family and
Accrued annual leave						_ Medical Leave Act of 1993 (FMLA), please
Restored annual leave						provide the following information:
Advance annual leave						 
✓ Accrued sick leave	5/22/15	5/22/15	0800	1700	8.00	to family and medical leave for:
Advance sick leave	<u> </u>	<u> </u>				Birth/Adoption/Foster care
Purpose: Illness/injury/incapacitation of requesting employee						
Medical/denta	l/optical examinatio	n of requesting emp	oloyee			spouse, son, daughter, or parent
Care of family bereavement	member, including	medical/dental/opt	ical examination o	of family member, or		Serious health condition of self
	member with a se	erious health conditio	סח			
Other						Contact your supervisor and/or your
						personnel office to obtain additional information about your entitlements and
Compensatory time off						responsibilities under the FMLA. Medical
Other paid absence (specify in remarks)						certification of a serious health condition may be required by your agency.
Leave without pay	-				-	1
6. Remarks			<u> </u>			
7. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.						
78			7b. Date signed			
						5/26/15
8a. Official action on rec	8a. Official action on request  Approved Disapproved (If disapproved, give reason. If annual leave, initiate action to reschedule.)					
8b. Reason for disapproval						
8c. Signature						8d. Date signed
						5/26/15
Privacy Act Statement						
						ary use of this information is by ssures of the information may be: To the
management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment						
compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal						
agency when conductin	g an investiga the informatio	tion for employ n is required fo	ment or secu or evaluation o	rity reasons; to t	he Office of	Personnel Management or the General ne General Services Administration in
Public Law 104-134 (Ar	oril 26, 1996) re	equires that an	y person doin	g business with	the Federa	al Government furnish a social security
number or tax identification number. This is an amendment to title 31, Section 7701. Furnishing the social security number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished						
on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.						

Office of Personnel Management 5 CFR 630

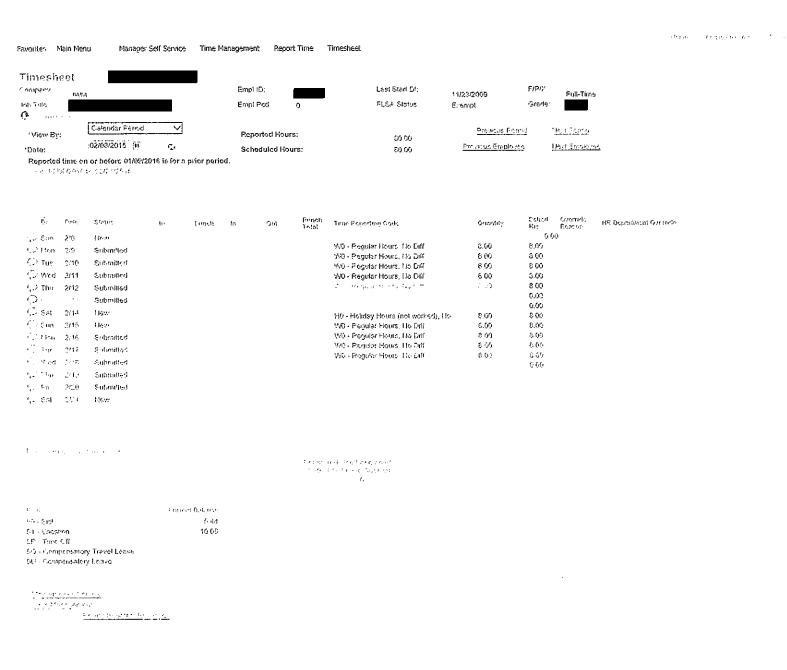


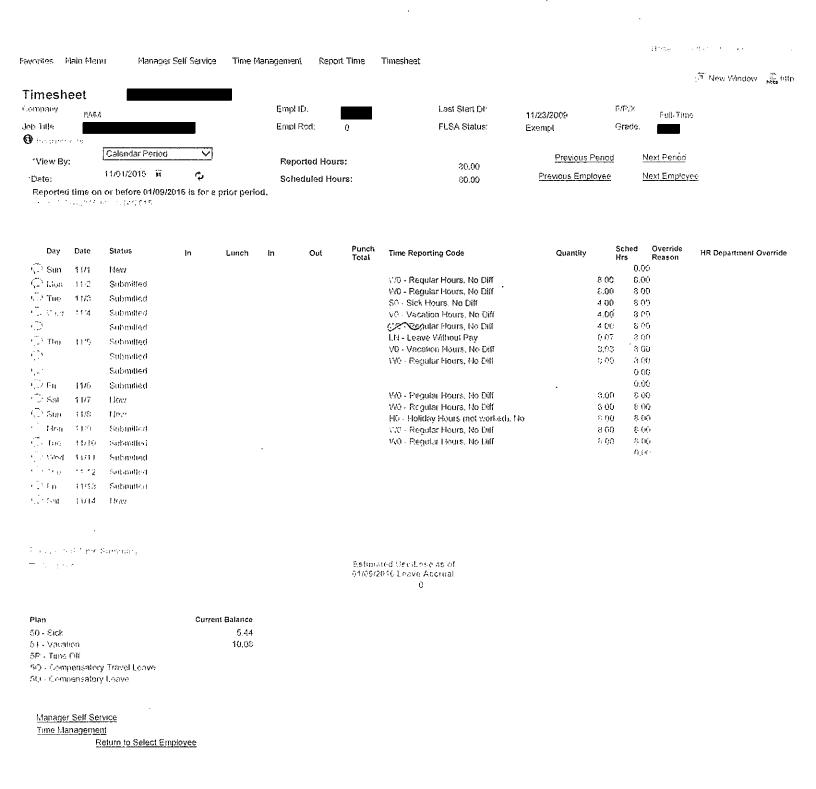
IWAKUNI BRANCH MEDICAL CLINIC 03 Aug 2015 1317 Page: 1
Personal Data - Privacy Act of 1974 (PL 93-579)

SPONSOR NAME: BILLING NAME: PSC 561 BOX 1 BILL ADDRESS: FPO AP 96310-0016 PATIENT NAME: ACCOUNT NO: SERVICE DATE: 10 Apr 2015@0834 / TOTAL CHARGES: \$26.60 Svc Code Description Qty Svc Date Sales Charges PHR I497822 60 10 Apr 2015 IOR DATE PAYMENT TYPE PAY CHECK NO. CTRL NO. BALANCE 27 Apr 2015 0.00 15-2532 26.60



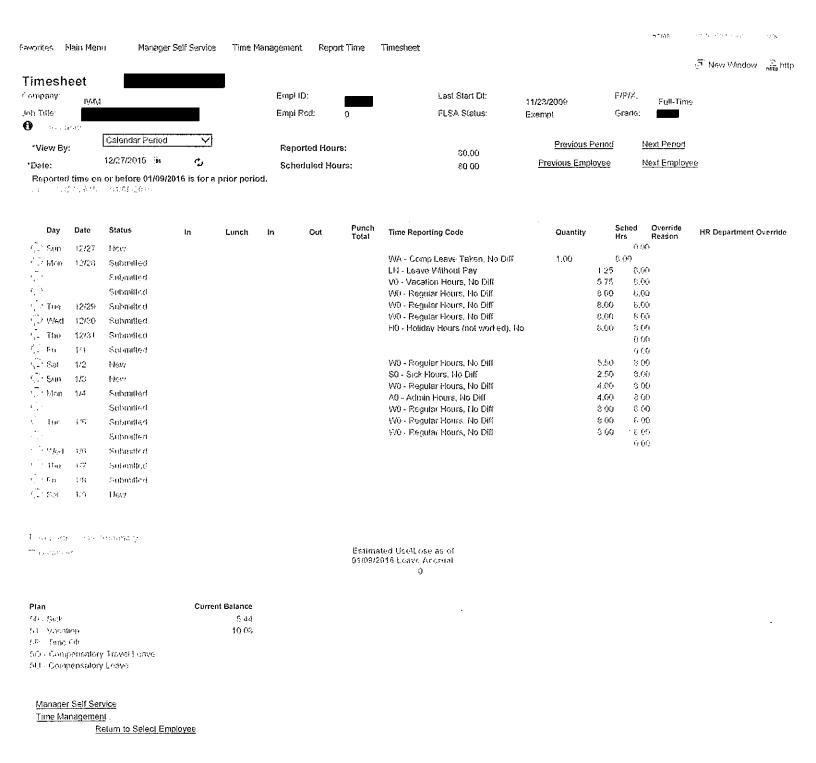
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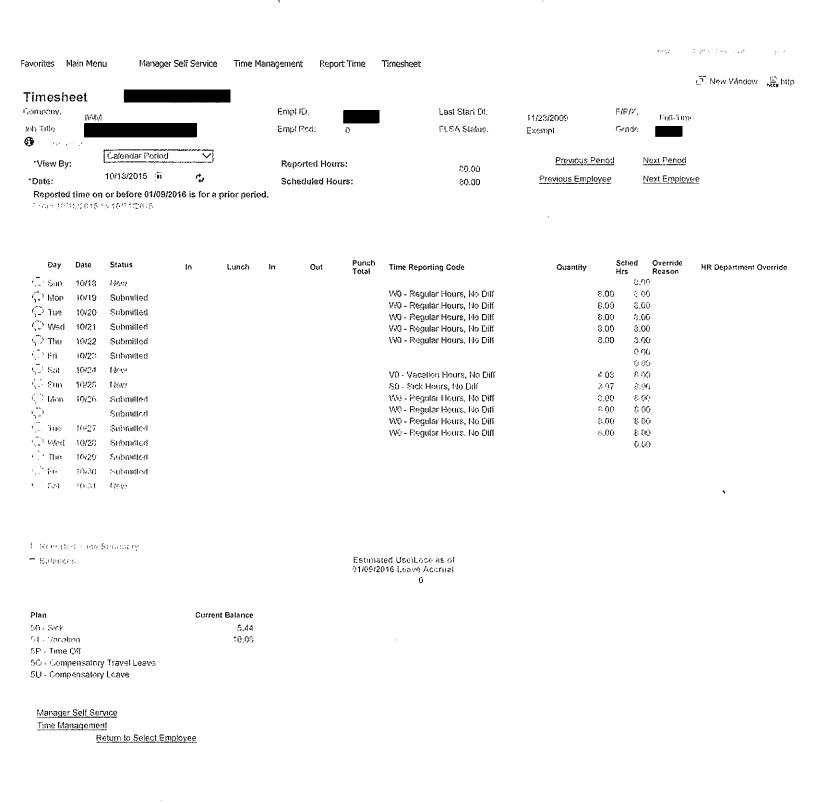


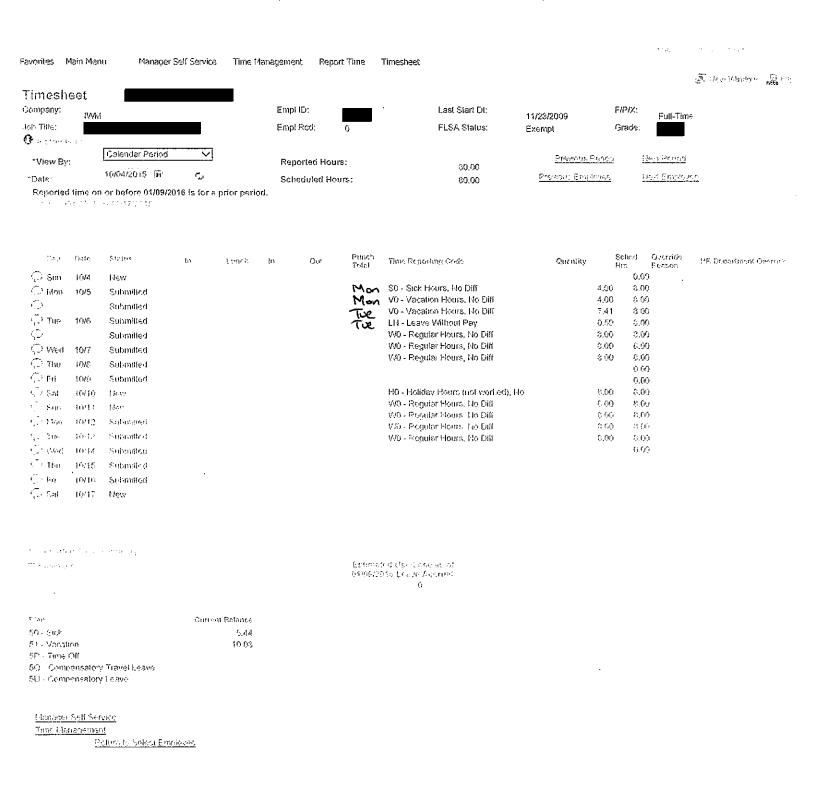
#### DISPLAY PATIENT APPOINTMENTS

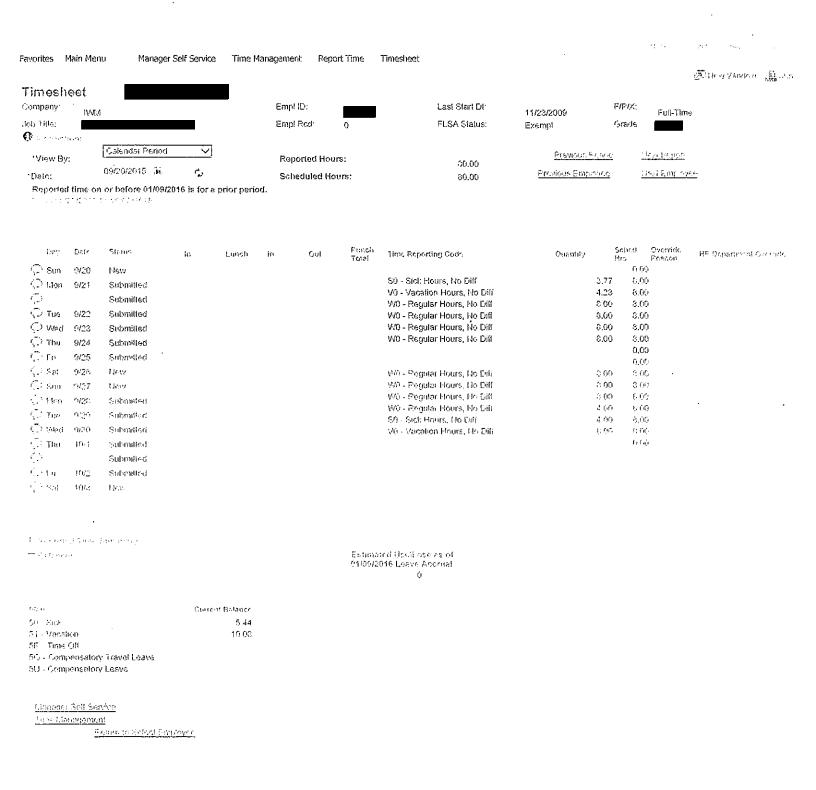
Personal Data - Privacy Act of 1974 (PL 93-579) PAST APPOINTMENT FOR Service 32/0251 DoD ID: 1502658499						
CLINIC/DIV	PROVIDER	DATE/TIME	TYPE/DUR DTL CODES	STATUS		
FPC MEDICAL HOME IWA/BMCIWA		23Jun2015@1004	T-CON*/15	TEL-CNSLT		
FPC MEDICAL HOME IWA/BMCIWA		25Jun2015@1000	FTR/60	KEPT APPT		
FPC MEDICAL HOME IWA/BMCIWA		25Jun2015@1506	T-CON*/15	TEL-CNSLT		
FPC MEDICAL HOME IWA/BMCIWA		01Jul2015@1222	T-CON*/15	TEL-CNSLT		
FPC MEDICAL HOME IWA/BMCIWA		17Jul2015@0800	SPEC/40	KEPT APPT		
FPC MEDICAL HOME IWA/BMCIWA		29Jul2015@0900	GRP/120	NO-SHOW		
FPC MEDICAL HOME IWA/BMCIWA		21Aug2015@0840	SPEC/20	KEPT APPT		
FPC MEDICAL HOME IWA/BMCIWA		01Sep2015@0847	T-CON*/15	TEL-CNSLT		
FPC MEDICAL HOME IWA/BMCIWA		08Sep2015@1015	T-CON*/15	TEL-CNSLT		
FPC MEDICAL HOME IWA/BMCIWA		010ct2015@0817	T-CON*/15	TEL-CNSLT		
FPC MEDICAL HOME IWA/BMCIWA		230ct2015@0900	SPEC/40 WEA	KEPT APPT		
FPC MEDICAL HOME IWA/BMCIWA		02Nov2015@1242	T-CON*/15	TEL-CNSLT		
FPC MEDICAL HOME IWA/BMCIWA		20Nov2015@0900	SPEC/20	KEPT APPT		
IMMUNIZATIONS - IWAK/BMCIWA		20Nov2015@0934	PROC\$/10	WALK-IN		
FPC MEDICAL HOME IWA/BMCIWA		24Nov2015@0847	T-CON*/15	TEL-CNSLT		
FPC MEDICAL HOME IWA/BMCIWA		01Dec2015@1252	T-CON*/15	TEL-CNSLT		
FPC MEDICAL HOME IWA/BMCIWA		07Dec2015@1052	T-CON*/15	TEL-CNSLT		

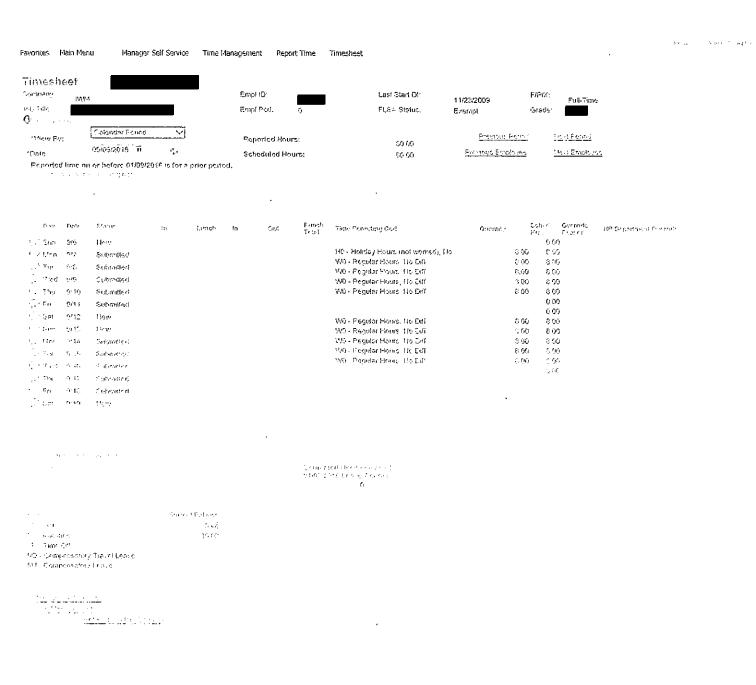


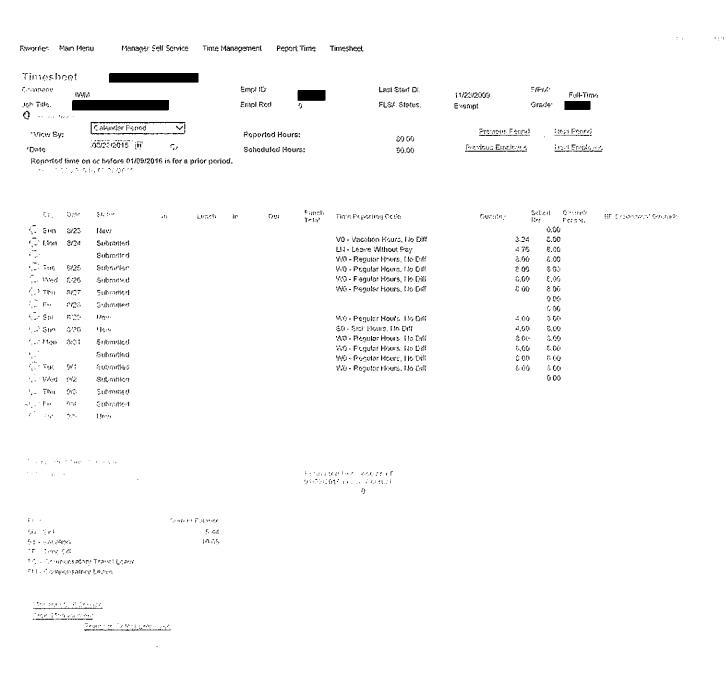
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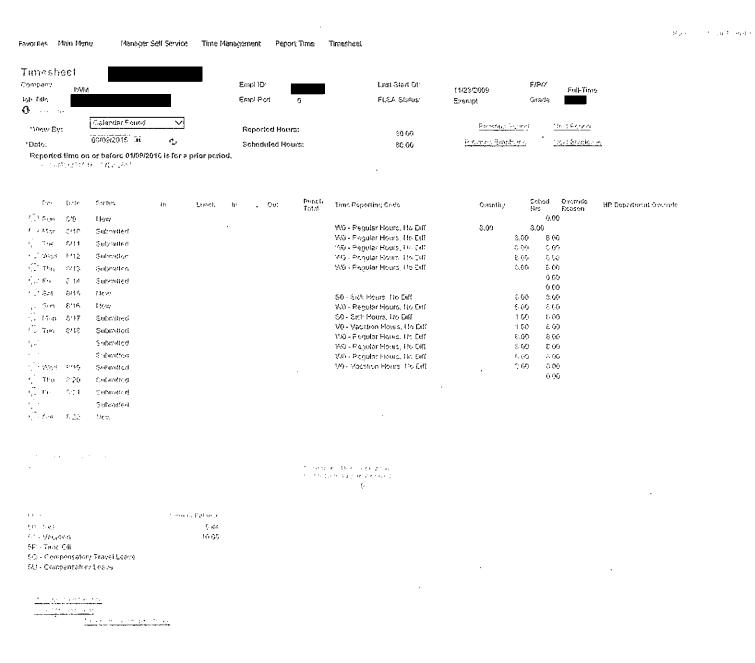


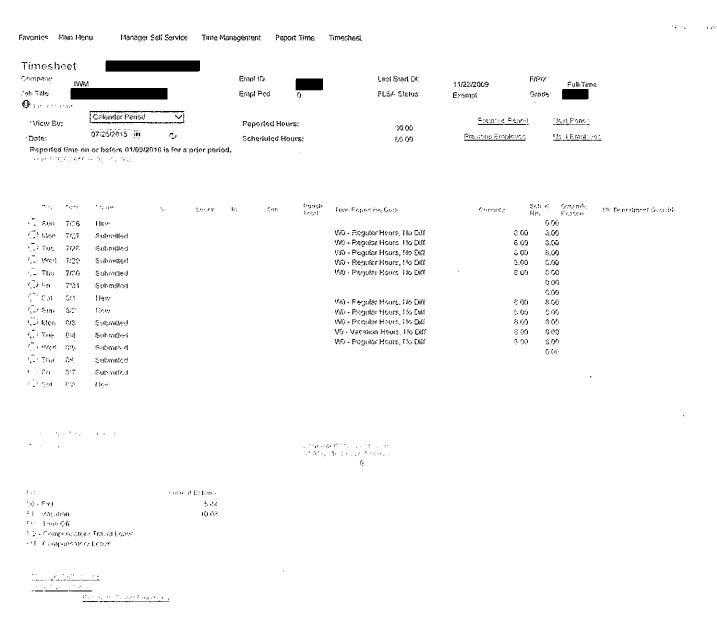


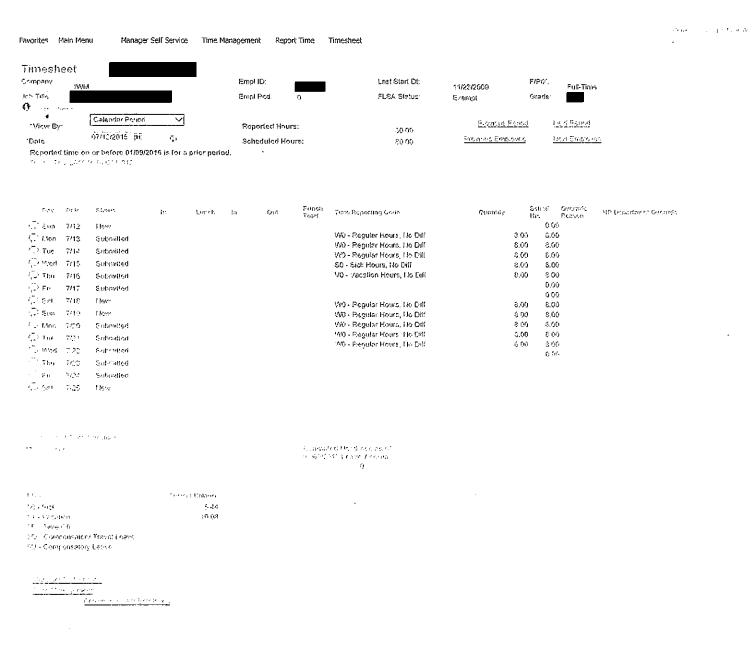




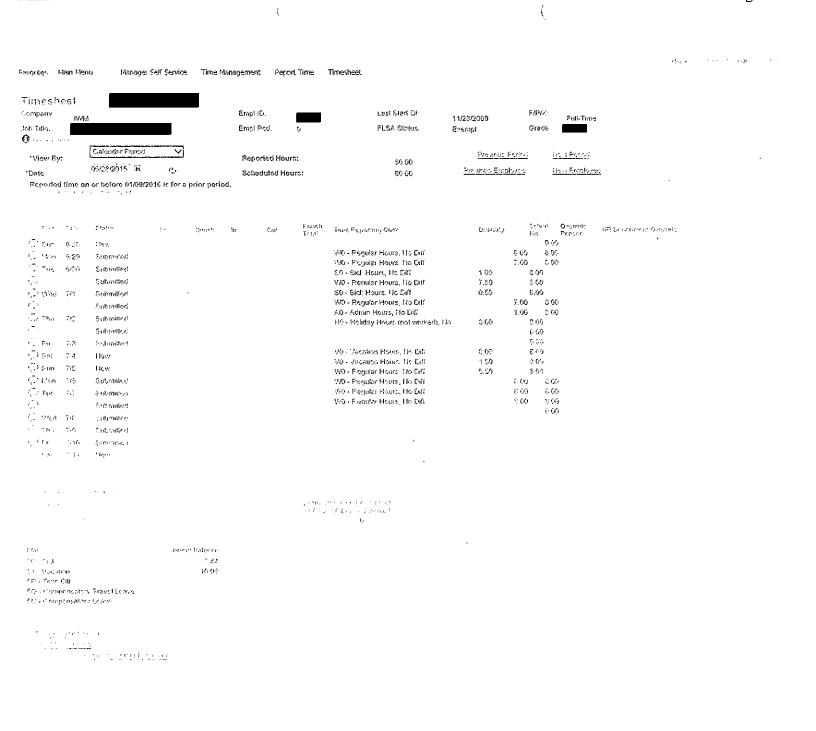


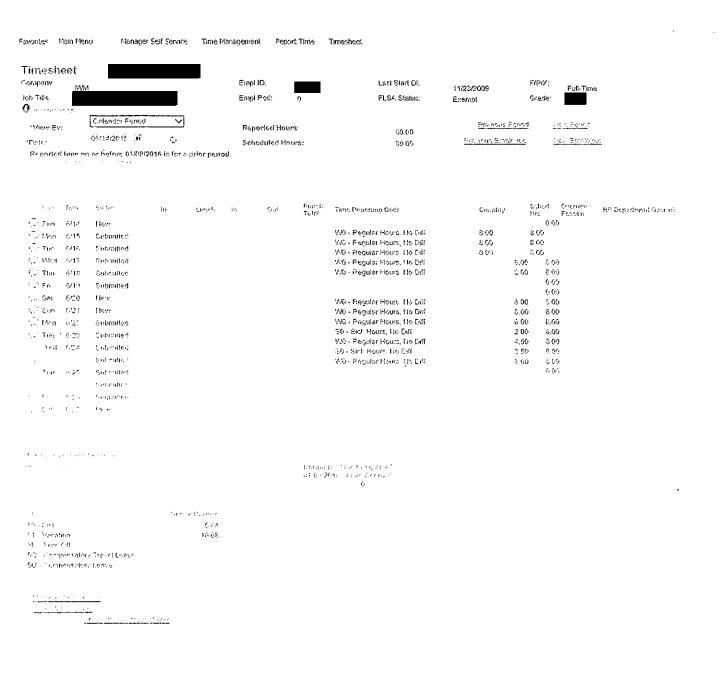


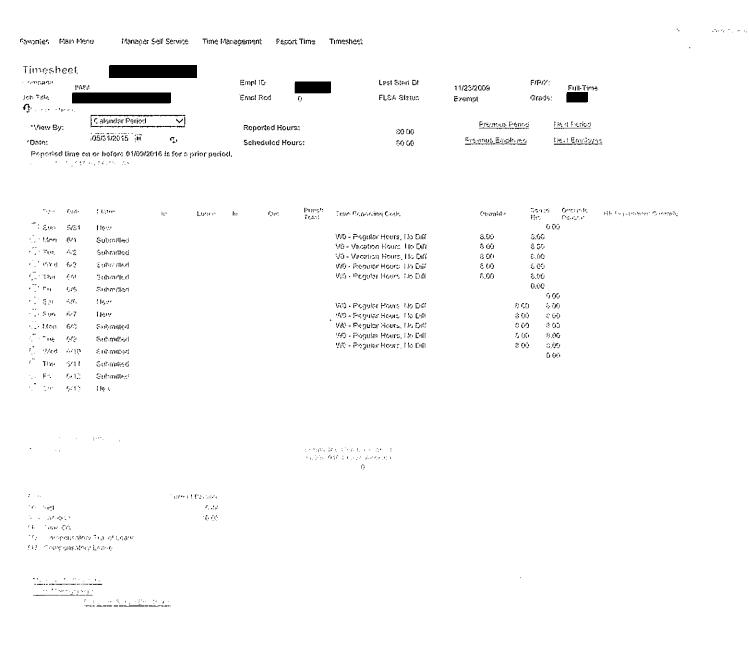


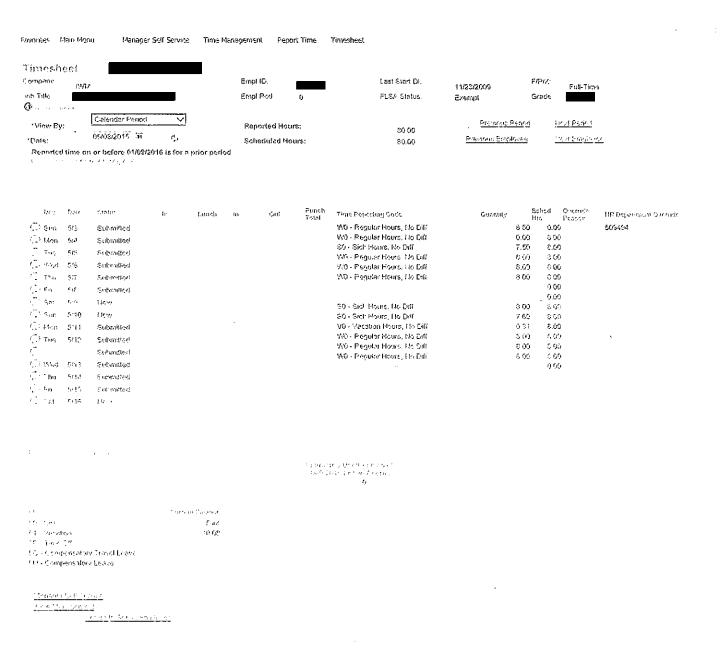


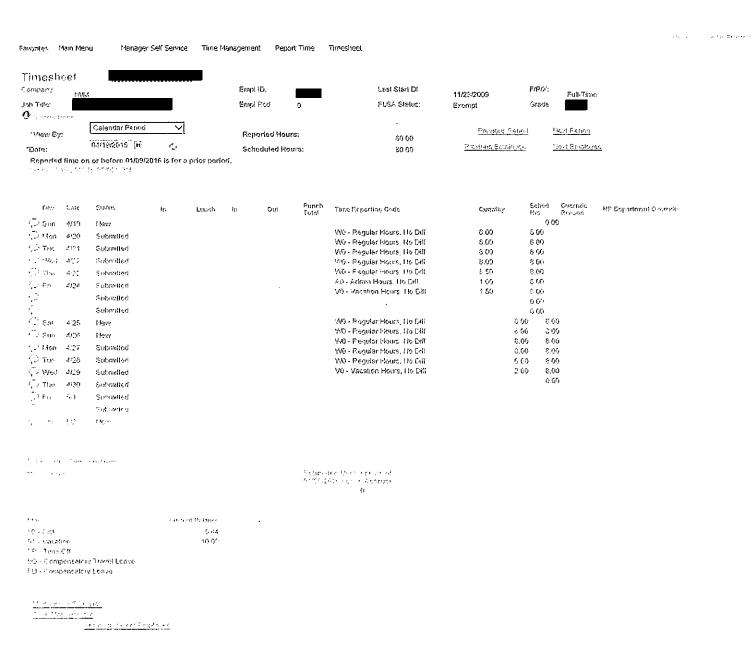
Timesheet Page 1 of 1



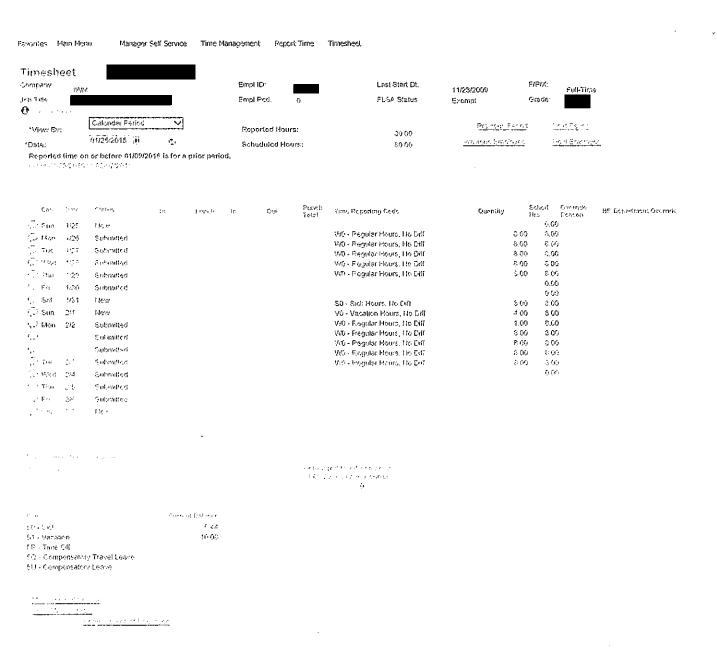


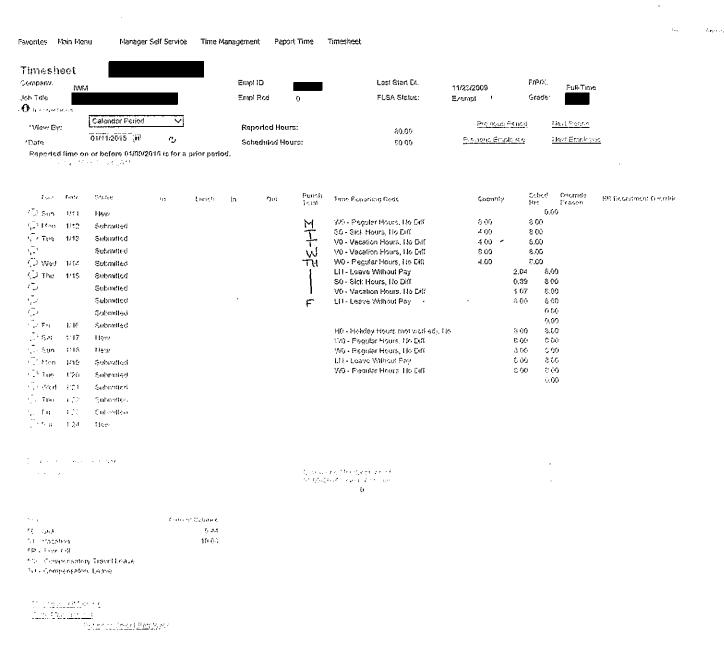


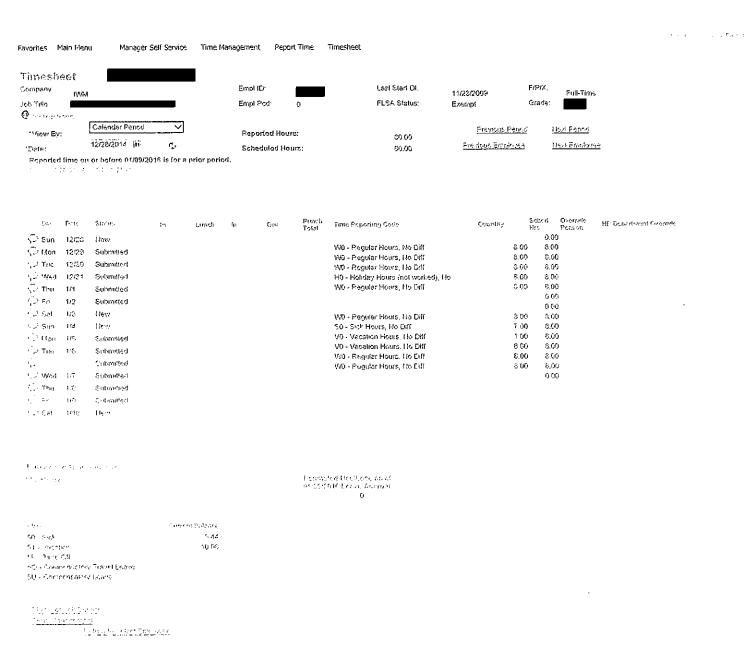


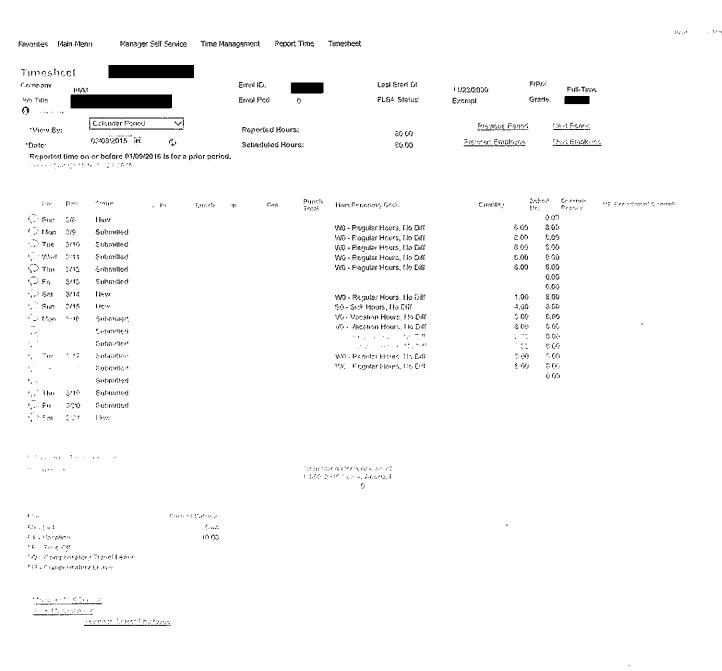


ENCLOSURENT







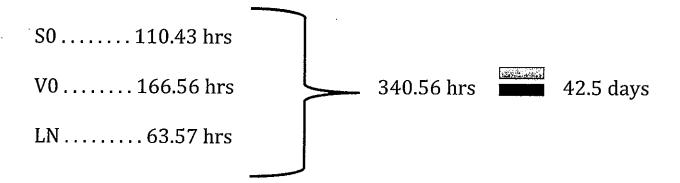


# Jan – Dec 2015

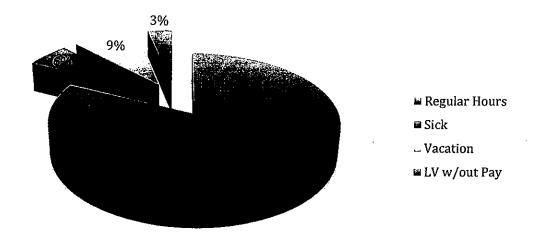
## Sick Leave (S0) / Vacation (V0) / Leave Without Pay (LN)

	Rah	Mari	A	Morr	Jun =
<u>Jan</u>	<u>Feb</u>	<u>Mar</u>	<u>Apr</u>	<u>May</u>	Jun 🚟
S0 11.89	S0 3.0	S0 10.0	S0 0.0	S027.69	S0 6.5
V0 22.07	V0 4.0	V017.0	VO 13.5	V05.81	V016.0
18.04	LN 0.0	LN 0.0	LN0.0	LN 0.0	LN 0.0
Total: 52 hrs	Total : 7 hrs	Total: 27 hrs  * Absent w/out leave reflected on time sheet (8 hrs)	Total : 13.5 hrs	Total : 33.5 hrs	Total : 22.5 hrs
<u>Jul</u>	Aug	<u>Sep</u>	<u>Oct</u>	Nov	<u>Dec</u>
\$0 8.5	.S013.0	S0 3.77	S012.03	S0 10.89	S0 3.16
V0 17.5	V0 14.24	V0 4.23	V023.44	V018.27	V010.5
LN 0.0	LN 4.76	LN0.0	LN 0.59	LN 22.84	LN 17.34
Total : 26 hrs	Total : 32 hrs	Total : 8 hrs	Total : 36.06 hrs	Total : 52 hrs	Total : 31 hrs

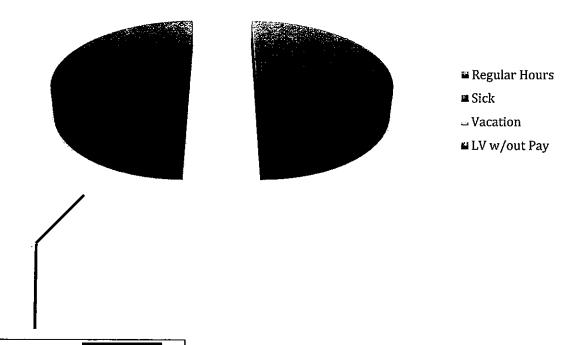
#### **ANNUAL GRAND TOTAL:**



# Percentage Breakdown per Timesheet



### Percentage Breakdown per Witness Observations



Time observed by witnesses of not at work, but timesheets reflect credited time & salary.

\*Figures are approximate.

-----<u>-----</u>-----

SPONSOR NAME:

BILLING NAME:

BILL ADDRESS:

FPO AP 96310-0016

PATIENT NAME:

ACCOUNT NO: SERVICE DATE:

OTC

27 Mar 2015@0842

TOTAL CHARGES: \$63.53

1 27 Mar 2015 VR3

15.47

------ CHARGES ------

 Svc
 Code
 Description
 Qty
 Svc Date
 Sales
 Charges

 LAB
 82465-00
 1 27 Mar 2015
 IOR
 5.76

 LAB
 89240-00
 2 27 Mar 2015
 IOR
 37.30

 PHR
 I496919
 100 27 Mar 2015
 IOR
 5.00

------ INVOICES & RECEIPTS ------

DATE	PAYMENT	TYPE PAY	CHECK NO.	CTRL NO.	BALANCE
13 Apr 2015	0.00			15-2206	154.42
03 Aug 2015	0.00			15-3516	48.06*
03 Aug 2015	0.00			15-3517	63.53*

<sup>\*</sup> Recalculated charges

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03 Aug 2015 1317 Page: 1 IWAKUNI BRANCH MEDICAL CLINIC Personal Data - Privacy Act of 1974 (PL 93-579)

SPONSOR NAME:

BILLING NAME:

BILL ADDRESS:

FPO AP 96310-0016

PATIENT NAME:

ACCOUNT NO:

TOTAL CHARGES: \$99.61 SERVICE DATE: 26 Mar 2015@0800 -

Svc Code OPE 99214-25 OPE 93000

<u>Description</u> <u>Q</u>ty

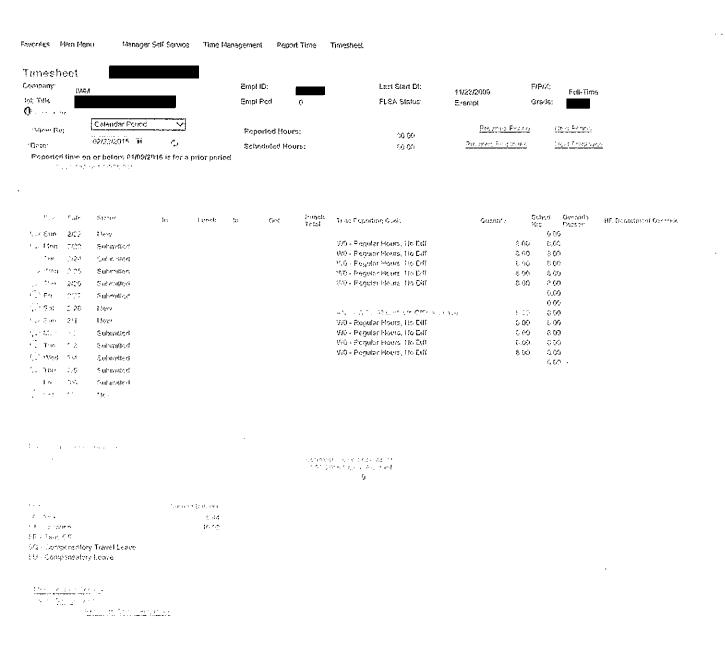
Svc Date Sales Charges 1 26 Mar 2015 IOR 86.16 1 26 Mar 2015 IOR 13.45

DATE PAYMENT TYPE PAY CHECK NO. CTRL NO. BALANCE

15-2597 99.61 03 May 2015 0.00

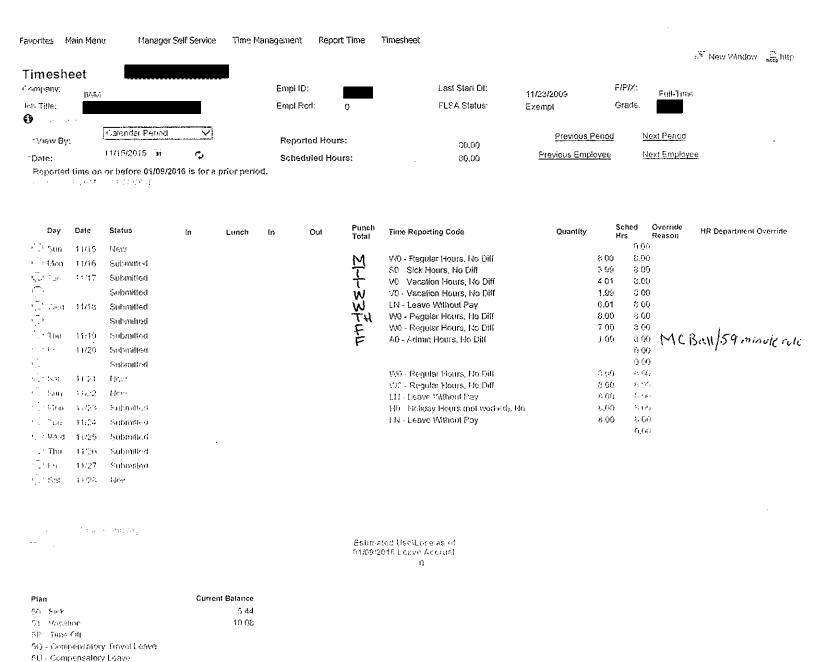
03 Aug 2015 1317 Page: 1 Personal Data - Privacy Act of 1974 (PL 93-579) SPONSOR NAME: BILLING NAME: BILL ADDRESS: FPO AP 96310-0016 PATIENT NAME: ACCOUNT NO: TOTAL CHARGES: \$27.72 SERVICE DATE: 18 Mar 2015@0853 V Svc Code Description Qty Svc Date Sales Charges PHR I496119 30 18 Mar 2015 IOR 6.80 PHR I496120 473 18 Mar 2015 IOR 20.92 PAYMENT TYPE PAY CHECK NO. CTRL NO. BALANCE DATE 04 Apr 2015 0.00 15-2087 27.72

IWAKUNI BRANCH MEDICAL CLINIC



Manager Self Service Time Management

Return to Select Employee



ENGLOSURE (H)

## DISPLAY PATTENT APPOINTMENTS

Personal Data	-	Privacy	Act	of	1974	(PL	93-579)	
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PAST APPOINTMENT FOR		20/0251 Do	D ID: 1 <b>1</b> 5476 TYPE/DUR	5715
CLINIC/DIV	PROVIDER	DATE/TIME	DTL CODES	STATUS
FPC MEDICAL HOME IWA/BMCIWA		26Mar2015@0800	FTR/20 WEA	KEPT APPT
FPC MEDICAL HOME IWA/BMCIWA		27Mar2015@1205	T-CON*/15	TEL-CNSLT
FPC MEDICAL HOME IWA/BMCIWA		10Apr2015@0820	FTR/20 WEA	KEPT APPT
OPTOMETRY - IWAKUNI/BMCIWA		15Sep2015@0940	SPEC/20	KEPT APPT
IMMUNIZATIONS - IWAK/BMCIWA		20Nov2015@0944	PROC\$/10	WALK-IN

	Relest for Leave or Approved Abseinge								
1. Name (Last, first, mi	iddle)				2.	Employee or Social Security Number			
						16580			
3. Organization				·-					
P&C									
4.	-	pe of Leave/A				5. Family and Medical Leave			
Check appropriate box(es) and enter date and time below)	Dat From	te To	From	ime To	Total Hour	s If annual leave, sick leave, or leave without			
✓ Accrued annual leave	12/28/15	12/28/15	0800	1345	5.75	pay will be used under the Family and			
Restored annual leave						Medical Leave Act of 1993 (FMLA), please provide the following information:			
Advance annual leave						7			
Accrued sick leave						I hereby invoke my entitlement to family and medical leave for:			
Advance sick leave			<u> </u>	<u> </u>	ļ	Birth/Adoption/Foster care			
Purpose: Illness/injury/incapacitation of requesting employee  Serious health condition of spouse, son, daughter, or parent									
_	l/optical examination		•	fomily meashes					
Care of family member, including medical/dental/optical examination of family member, or bereavement Serious health condition of self									
Care of family member with a serious health condition									
Other Contact your supervisor and/or your personnel office to obtain additional									
[] 0	40/00/45	40,00,145	4445	4545	4.00	information about your entitlements and responsibilities under the FMLA. Medical			
Compensatory time off	12/28/15	12/28/15	1445	1545 \	1.00	<ul> <li>certification of a serious health condition</li> </ul>			
Other paid absence (specify in remarks)						may be required by your agency.			
✓ Leave without pay	12/28/15	12/28/15	1545	1700	1.25				
6. Remarks									
Previously sche	eduled leav	e. Chan	sect from	n 12/31.					
emploving agency's	procedures for	requesting lea	ave/approved a	bsence (and pr	rovide add	ted. I understand that I must comply with my itional documentation, including medical or disciplinary action, including removal.			
7a.						7b. Date signed 17/29/15			
8a. Official action on re-	quest	Approv	ed	Disapproved		approved, give reason. If annual leave, e action to reschedule.)			
8b. Reason for disappr	oval								
8c. Signa	<u> </u>					8d. Date signed			
						12/29/15			
Privacy Act Statement Section 6311 of title 5,	t United States (	Code, authorize	es collection of	this information	n. The prin	nary use of this information is by			

connection with its responsibilities for records management.

		Reques	t for Leav	e or Appro	ved Al	osei	nce		
1. Name (Last, first, m.	iddle)				·	2.	Employee or Social Security Number		
3. Organization P&C				-					
4	7	ype of Leave/	Absence				5. Family and Medical Leave		
Check appropriate box(es) and enter date and time below)		ate		Time	Total H	lours	If annual leave, sick leave, or leave without		
Accrued annual leave	From 10/16/15	To 10/16/15	1530	1700	1.50		pay will be used under the Family and Medical Leave Act of 1993 (FMLA), please		
Restored annual leave			<del> </del>				provide the following information:		
Advance annual leave					-		I hereby invoke my entitlement to family and medical leave for:		
Advance sick leave			· ·						
Purpose: Illness/injury/ii		questing employee	-!			<del></del>	Birth/Adoption/Foster care		
	•	questing employee on of requesting em	nlovoe				Serious health condition of spouse, son, daughter, or paren		
_	•		, ,	of family member,	or		Serious health condition of self		
<del></del>	member with a si	erious health conditi	ion				_		
Other	mombol mar a c	57,555 T155151 5577415					Contact your supervisor and/or your		
							personnel office to obtain additional information about your entitlements and		
Compensatory time off							responsibilities under the FMLA. Medical certification of a serious health condition		
Other paid absence (specify in remarks)							may be required by your agency.		
Leave without pay			<u> </u>				·		
Remarks     Remarks     Remarks     Remarks	that the leave	/absence requ	ested above	is for the purpo	ese(s) ind	icate	d. I understand that I must comply with my		
employing agency's certification, if require	procedures fo ed) and that fa	r requesting le	ave/approved formation on	l absence (and this form may l	l provide a be ground	addiți ds for	onal documentation, including medical disciplinary action, including removal.		
7a. Employ							7b. Date signed 10/10/15		
8a. Official		Approv	red	Disapprov			proved, give reason. If annual leave, action to reschedule.)		
8b. Reason for disappro	oval						·		
		$\wedge$							
8c. Signatu							8d. Date signed		
							10/16/15		
management and your	Jnited States ( payroll office t	o approve and	record your u ompensation	ise of leave. Ad Fregarding a lo	lditional d b connec	isclo ted ir	ry use of this information is by sures of the information may be: To the hjury or illness; to a State unemployment egarding a claim; to a Federal, State, or		

local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.

		Request	for Leave	or Appro	ved Abs	ence
1. Name (Last, first, mi	iddle)		···		2.	Employee or Social Security Number
3. Organization				<u> </u>		
P&C						•
4.	T	5. Family and Medical Leave				
Check appropriate box(es) and enter date and time below)		ate		Time	Total Hou	
✓ Accrued annual leave	From 9/11/15	9/11/15	From 1500	1700	2.00	pay will be used under the Family and Medical Leave Act of 1993 (FMLA), please
Restored annual leave			<b>.</b>			provide the following information:
Advance annual leave		<u> </u>	ļ <u>.                                    </u>		_	I hereby invoke my entitlement
Accrued sick leave Advance sick leave		-	<u> </u>			to family and medical leave for:
			I	<u></u>	<u> </u>	Birth/Adoption/Foster care
	•	questing employee on of requesting emp	plovee			Serious health condition of spouse, son, daughter, or parent
_	•	g medical/dental/opt	•	family member,	or	Serious health condition of self
Care of family	member with a se	erious health condition	on			
Other		Contact your supervisor and/or your personnel office to obtain additional				
Compensatory time off				<u> </u>		information about your entitlements and responsibilities under the FMLA. Medical
Other paid absence (specify in remarks)			<u></u>			certification of a serious health condition may be required by your agency.
Leave without pay						
emploving agency's	procedures fo	r requesting le	ave/approved	absence (and	provide ad-	ted. I understand that I must comply with my ditional documentation, including medical for disciplinary action, including removal.
7a. En						7b. Date signed
8a. Official action on rec	quest	Approv	ed [	Disapprove	ed (If dis	approved, give reason. If annual leave, e action to reschedule.)
8b. Reason for disappr	oval					
8c. Signat					<del>.</del>	8d. Date signed
1						11 Sapt 15
management and your Department of Labor w compensation office re local law enforcement agency when conductin Accounting Office wher connection with its resident programmer or tax identifications after involvement	United States payroll office then processing arding a claimagency when the information ponsibilities for pril 26, 1996) atton number.	to approve and a claim for com; to Federal L your agency be ation for employ on is required for records manarequires that ar This is an ame	record your us ompensation ife Insurance comes aware yment or secu- or evaluation of agement.  The person doing the person do	se of leave. Ad regarding a jol or Health Bene of a violation or rity reasons; to fleave admining business we 31, Section 7 ction on the action of the section	ditional disc b connected efits carriers or possible to the Office istration; or with the Fede 701. Furnis	mary use of this information is by closures of the information may be: To the dinjury or illness; to a State unemployment is regarding a claim; to a Federal, State, or violation of civil or criminal law; to a Federal of Personnel Management or the General the General Services Administration in eral Government furnish a social security hing the social security number, as well as your agency uses the information furnished ional statement reflecting those purposes.

Office of Personnel Management 5 CFR 630

Request for Leave or Approved Absence										
1. Name (Last, first, mi	iddle)				2.	Employee or Social Security Number				
Organization				····						
P&C										
	M11				<u> </u>					
4.		ype of Leave/A	·	Time	<del></del>	5. Family and Medical Leave				
Check appropriate box(es) and enter date and time below)	From	te To	From	If annual leave, sick leave, or leave without						
✓ Accrued annual leave	7/7/15	7/7/15	1530	1700	1.50	pay will be used under the Family and Medical Leave Act of 1993 (FMLA), please				
Restored annual leave						provide the following information:				
Advance annual leave			<u> </u>			I hereby invoke my entitlement				
Accrued sick leave	<u> </u>	<del> </del>	<del> </del>		<del></del>	to family and medical leave for:				
Advance sick leave			<u></u>		<u> </u>	Birth/Adoption/Foster care				
	Serious health condition of									
Care of family	nl/optical examination  member, including			of family member, o	or	Serious health condition of self				
bereavement bereavement	_			,						
	member with a ser	rious health condition	חכ			<u> </u>				
Other						Contact your supervisor and/or your personnel office to obtain additional				
Compensatory time off				<del></del>	<del>1</del>	information about your entitlements and responsibilities under the FMLA. Medical				
Other paid absence	<u></u> J		<del>                                     </del>	<del> </del>	-	certification of a serious health condition				
(specify in remarks)		<del> </del>	<u></u>			may be required by your agency.				
Leave without pay	<u> </u>									
6. Remarks										
employing agency's p	procedures for	requesting lea	ave/approved a	absence (and p	provide additi	d. I understand that I must comply with my ional documentation, including medical disciplinary action, including removal.				
7a.					7 9. 0 2 2	7b. Date signed				
						70. Date signed 7/7/15				
8a. Official action on req	uest	Approve	ed [	Disapprove		proved, give reason. If annual leave, action to reschedule.)				
8b. Reason for disappro	val									
8c. Signati						Od Data signed				
oc. Signate						8d. Date signed				
						07/07/15				
Privacy Act Statement Section 6311 of title 5, U		ode, authorize	s collection of	this informatio	n. The prima	ry use of this information is by				
management and your p	payroll office to	approve and re	record your use	e of leave. Addi	itional disclos	sures of the information may be: To the ijury or illness; to a State unemployment				

Request for Leave or Approved Absence									
1. Name (Last, first, mi	iddle)			·	2.	Employee or Social Security Number			
<ol><li>Organization</li></ol>				***					
P&C									
4	Ту	5. Family and Medical Leave							
Check appropriate box(es) and enter date and time below)				ime	Total Hours	If annual leave, sick leave, or leave without			
Accrued annual leave	From 6/30/15	To 6/30/15	From 1030	1130	1.00	pay will be used under the Family and			
Restored annual leave	7/1/15	7/1/15	0800	0900	1.00	Medical Leave Act of 1993 (FMLA), please provide the following information:			
Advance annual leave	17 17 10		0000	0000		provide the following information.			
Accrued sick leave						I hereby invoke my entitlement to family and medical leave for:			
Advance sick leave				,		Birth/Adoption/Foster care			
= '	capacitation of req	Serious health condition of spouse, son, daughter, or parent							
	l/optical examination								
Care of family member, including medical/dental/optical examination of family member, or bereavement Serious health condition of self									
Care of family	member with a se	rious health conditio	n			,			
Other						Contact your supervisor and/or your personnel office to obtain additional			
		<del></del>		1	1	information about your entitlements and			
Compensatory time off	····					responsibilities under the FMLA. Medical certification of a serious health condition			
Other paid absence (specify in remarks)						may be required by your agency.			
Leave without pay									
6. Remarks				•	•				
<u>.</u> .									
						d. I understand that I must comply with my			
						onal documentation, including medical disciplinary action, including removal.			
7a						7b. Date signed			
						7/6/15			
8a. Oniciai action on req	uest	➤ Approve	ed [	Disapproved		proved, give reason. If annual leave, action to reschedule.)			
8b. Reason for disappro	oval								
8c. Signa						8d. Date signed			
					•	7/2/10			
						(/ 7 / 1 )			
Privacy Act Statement	Initial 01-1 0		a aalla sii'ee d		- The	and the lands are also be			
						ry use of this information is by sures of the information may be: To the			

		Reques	t for Leave	e or Approv	ed Absei	nce
1. Name (Last, first, m	iddle)		-		2.	Employee or Social Security Number
<ol><li>Organization</li></ol>						
P&C						
4.	T	ype of Leave/A	bsence	<del>- **</del>	·····	5. Family and Medical Leave
Check appropriate box(es) and enter date and time below)		ate		Time	Total Hours	If annual leave, sick leave, or leave without
Accrued annual leave	From '	То	From	То		pay will be used under the Family and
Restored annual leave					+	Medical Leave Act of 1993 (FMLA), please provide the following information:
Advance annual leave						_
Accrued sick leave	6/25/15	6/25/15	0800	1130	3.50	I hereby invoke my entitlement to family and medical leave for:
Advance sick leave	l					Birth/Adoption/Foster care
Purpose: Illness/injury/ir	ncapacitation of red	questing employee				Serious health condition of
<del></del>		on of requesting em	• •			spouse, son, daughter, or parent
Care of family bereavement	member, including	g medical/dental/op	tical examination o	of family member, or	•	Serious health condition of self
_		erious health conditi		I		
Other						Contact your supervisor and/or your
			7		<del>.   </del>	personnel office to obtain additional information about your entitlements and
Compensatory time off						responsibilities under the FMLA. Medical certification of a serious health condition
Other paid absence (specify in remarks)		•				may be required by your agency.
Leave without pay						
6. Remarks						
						d. I understand that I must comply with my
						onal documentation, including medical disciplinary action, including removal.
	eu) anu jat la	isincation of im	iorniation on t	nis ioni may be	grounds for	
7a. E						7b. Date signed
						9105/15
8a. Official action on rec	quest	Approv	ed [	Disapproved	1	proved, give reason. If annual leave, action to reschedule.)
8b. Reason for disappro	oval					
				•		
8c. Signature						8d. Date signed
•						
						25 lue 85
Privacy Act Statement Section 6311 of title 5, U	United States	Code, authorize	es collection o	f this information	n. The prima	ry use of this information is by

1. Name (Last, first, middle)  2. Employee or Social Security Number  P&C  4. Type of LeavelAbsence  4. Type of LeavelAbsence  5. Family and Medical Leave  Cheese spepriate box(es) and Date Time Total Hour PACCED Annual leave (Leave Annual leave)  1. Pacetad annual leave   From To From To From To From To Pacetad annual leave   Pacetad Annual	Request for Leave or Approved Absence									
## P&C  4. Type of Leave/Absence  4. Type of Leave/Absence  4. Type of Leave/Absence  5. Family and Medical Loave  Tental Hours  1 If annual leave, sick leave, or leave without part of the sudding and the leave without part of the sudding and the leave without part of the sudding and the leave without part of the leave without p	1. Name (Last, first, m	iddle)		•		2.	Employee or Social Security Number			
## P&C  4. Type of Leave/Absence  4. Type of Leave/Absence  4. Type of Leave/Absence  5. Family and Medical Loave  Tental Hours  1 If annual leave, sick leave, or leave without part of the sudding and the leave without part of the sudding and the leave without part of the sudding and the leave without part of the leave without p										
4. Type of Leave/Absence 5. Family and Medical Leave Check appropriate box(es) and Date Time To From T										
Compensatory time off   Comp	P&C									
and the blook provide the following information:    Accrued annual leave	4.	T	ype of Leave/A	Absence		5. Family and Medical Leave				
Accrued annual leave						Total Hours	If annual leave, sick leave, or leave without			
Reatored annual leave		PIOIII	10	From	10					
Acrued sick leave    Acrued sick leave   Advance annual leave   Advance sick leave   Birth/Adopticn/Foster care   Care of family member, including medical/dental/optical examination of family member, or   Serious health condition of spouse, son, daughter, or parent   Serious health condition of self   Care of family member with a serious health condition   Compensatory time off   Serious health condition   Compensatory time off	Restored annual leave				<del></del>					
Advance sick leave  Purpose:   Illness/qiury/incapacitation of requesting employee   Serious health condition of spouse, son, daughter, or parent   Serious health condition of spouse, son, daughter, or parent   Serious health condition of spouse, son, daughter, or parent   Serious health condition of spouse, son, daughter, or parent   Serious health condition of spouse, son, daughter, or parent   Serious health condition of spouse, son, daughter, or parent   Serious health condition of spouse, son, daughter, or parent   Serious health condition of self between   Serious health condition of serious health	Advance annual leave						]			
Purpose: Illness/rijury/incapaciation of reguesting employee   Medical/doctal/optical examination of requesting employee   Care of family member, including medical/doctal/optical examination of requesting employee   Care of family member with a serious health condition   Other	I <i>=</i>	6/24/15	6/24/15	0800	1000	2.00	to family and medical leave for:			
Medical/denial/optical examination of requesting employee   Spruse, son, daughter, or parent   Spruse, son, daughter, or parent   Serious health condition of self   Serious health condition of self   Serious health condition   Compensatory time off   Compensatory time	Advance sick leave						Birth/Adoption/Foster care			
Medicalidental/optical examination of requesting employee   Spouse, son, daughter, or parent   Serious health condition   Compensatory time off   Serious health condition   Serious health condi	Purpose: Illness/injury/i	ncapacitation of red	questing employee				Serious health condition of			
Care of family member, including medical/dental/optical examination of family member, or bereavement.   Serious health condition of self bereavement and or your supervisor and/or your personnel office to obtain additional information about your entitlements and responsibilities under the FMIJ. A Medical cartification of a serious health condition may be required by your agency.		•		plovee						
Care of family member with a serious health condition   Other   Other	Care of family				family member or		Serious health condition of self			
Compensatory time off Compensatory time off Compensatory time off Other paid absence (specify in remarks) Leave without pay  6. Remarks  7. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.  7a.  7b. Date signed  6 Disapproved  7b. Reason for disapproval  8c.  d. Date signed  6 Disapproved  6 Disapproved  7c.  Approved  7c.  Approved  7c.  Approved  Appr		member with a se	erious health conditi	on						
Compensatory time off	<u>—</u>		11000				Contact your supervisor and/or your			
Compensatory time off Other paid absence (specify in remarks) Leave without pay 6. Remarks  7. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.  7a.  7b. Date signed  7b. Date signed  7c. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.  7a.  7b. Date signed  6c.  7c. Certification: I certify that the leave/absence requested above is for the purposed.  7c. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency action, including removal.  7a.  7b. Date signed  6c.  6c.  6c.  6c.  6c.  6c.  6c.  6c	[						personnel office to obtain additional			
Diter paid absence (specify in remarks)   Leave without pay	Compensatory time off						responsibilities under the FMLA. Medical			
Leave without pay  6. Remarks  7. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.  7a.  7b. Date signed  7c. Certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.  8a. Ombier action to reschedule.)  8b. Reason for disapproval  8c.  d. Date signed  6c.  d. Date signe	Other paid absence									
7. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.  7a.  7b. Date signed  6c.  7c. Date signed  6c.  7c. Date signed  6c.  6c.  7c. Date signed  6c.  6c.  6c.  6c.  6c.  6c.  6c.  6c	I						·			
7. Certification: I certify that the leave/absence requested above is for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.  7a.			<u> </u>	<u> </u>		<u> </u>	1			
8a. Onlicer action of request  Approved  Disapproved  (If disapproved, give reason. If annual leave, initiate action to reschedule.)  8b. Reason for disapproval  8c.  d. Date signed  L/23//5  Pri Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.  Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security	employing agency's	procedures fo	r requesting le	ave/approved a	ibsence (and p	rovide addit	ional documentation, including medical			
Bb. Reason for disapproval  8c.  d. Date signed    23   15	7a.									
Pri Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.  Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security	8a. Omolai agusti on rec	quest	Approv	ed	Disapproved	1 ' '	• •			
Pri Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.  Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security	8b. Reason for disappr	oval								
Pri Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.  Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security	8c.						•			
number or tax identification number. This is an amendment to title 31, Section 7701. Furnishing the social security number, as well as	Section 6311 of title 5, to management and your Department of Labor work compensation office relocal law enforcement agency when conducting Accounting Office when connection with its responsive Law 104-134 (Alexandre)	payroll office to hen processin garding a clair agency when y ag an investiga the informatic consibilities for pril 26, 1996) r	o approve and g a claim for con; to Federal Li our agency be tion for employ in is required for records manage guires that an equires that an	record your use ompensation re ife Insurance o comes aware coment or securior evaluation of agement.	e of leave. Adding a job or the alth Benefit of a violation or ty reasons; to the average administration of the average and th	tional disclo connected in ts carriers n possible vig he Office of tration; or th the Federa	ary use of this information is by sures of the information may be: To the injury or illness; to a State unemployment egarding a claim; to a Federal, State, or olation of civil or criminal law; to a Federal Personnel Management or the General e General Services Administration in			

Office of Personnel Management 5 CFR 630 OPM Form 71 June 2001

other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

	Request for Leave or Approved Absence									
1.	Name (Last, first, mi	iddle)				2.	Employee or Social Security Number			
3.	Organization					<del> </del>				
	P&C						·			
4.		T:	/pe of Leave/A	bsence		<del>, , ,</del> ,	5. Family and Medical Leave			
	eck appropriate box(es) and er date and time below)				Time	Total Hours				
<u> </u>	Accrued annual leave	From 7/6/15	7/6/15	From 0800	To 1700		pay will be used under the Family and			
F	Restored annual leave	110/13	770/13	0000	1700	8.00	Medical Leave Act of 1993 (FMLA), please			
F	Advance annual leave	<del></del>		<del> </del>			provide the following information:			
	Accrued sick leave	<del></del>		<del> </del>		<u> </u>	I hereby invoke my entitlement to family and medical leave for:			
	Advance sick leave						Birth/Adoption/Foster care			
Pu	rpose: [] [[]ness/injury/ir	capacitation of req	uestina employee							
	= ' '	optical examinatio		Serious health condition of spouse, son, daughter, or parent						
	Care of family	member, including	r	Serious health condition of self						
	bereavement Serious health condition									
	Other	member will a se	HOUS NESSET CORUM	л			Contact your supervisor and/or your			
							personnel office to obtain additional			
Г	Compensatory time off			<u> </u>	1	1	information about your entitlements and responsibilities under the FMLA, Medical			
Ξ	Other paid absence	·			<del>                                     </del>		certification of a serious health condition may be required by your agency.			
느	(specify in remarks)				<u> </u>		may be required by your agency.			
Ļ	Leave without pay			<u> </u>	<u>                                     </u>					
6.	Remarks									
		•								
_										
							d. I understand that I must comply with my onal documentation, including medical			
							disciplinary action, including medical			
7a.	Em						7b. Date signed			
							6/11/15			
8a.	Official action on red	uest		<u>,                                    </u>	_	(If disan	proved, give reason. If annual leave,			
			Approve	ed _	Disapproved		action to reschedule.)			
8b.	Reason for disappro	val	· ·				<del> </del>			
		•								
8c.	Signatur						8d. Date signed			
							06/11/15			
	vacy Act Statement	-it  Ot-t	ada auti i		Alexander III					
ma	inagement and vour	onned States Coayroll office to	oue, authorize approve and r	ecord your use	uns information of leave. Addi	n. The prima tional disclos	ry use of this information is by sures of the information may be: To the			

Request for Leave or Approved Absence									
1. Name (Last, first, m.	iddle)		,	•	2.	Employee or Social Security Number			
2 0				···					
3. Organization									
P&C				***					
4.		/pe of Leave/A				5. Family and Medical Leave			
Check appropriate box(es) and enter date and time below)	From Da	te I To	From	Time To	Total Hours	If annual leave, sick leave, or leave without			
Accrued annual leave	6/2/15	6/3/15	0800	1700	16.00	pay will be used under the Family and Medical Leave Act of 1993 (FMLA), please			
Restored annual leave						provide the following information:			
Advance annual leave						I hereby invoke my entitlement			
Advance sick leave			<u> </u>	ļ		to family and medical leave for:			
Advance sick leave			1			Birth/Adoption/Foster care			
	ncapacitation of req					Serious health condition of spouse, son, daughter, or parent			
	l/optical examination		-	of family member, or					
bereavement	member, including	medicardentaropt	icai examination c	s raininy member, or		Serious health condition of self			
Care of family	member with a se	rious health conditio	nc						
Other						Contact your supervisor and/or your personnel office to obtain additional			
			1	1	1 .	information about your entitlements and			
Compensatory time off					<u> </u>	responsibilities under the FMLA. Medical certification of a serious health condition			
Other paid absence (specify in remarks)					<u> </u>	may be required by your agency.			
Leave without pay									
6. Remarks					•				
						d. I understand that I must comply with my			
						ional documentation, including medical disciplinary action, including removal.			
7a. F						7b. Date signed			
						6/4/15			
8a. Official action on red	quest	Approve	ed [	Disapproved	3 ' '	pproved, give reason. If annual leave, action to reschedule.)			
8b. Reason for disappro	oval				*				
8c. Signati						8d. Date signed			
Co. Oignate									
,						6/4/15			
Privacy Act Statement			<del></del>	. =:::					
Section 6311 of title 5, l	Jnited States C					ry use of this information is by sures of the information may be: To the			

Request for Leave or Approved Absence									
1. Name (Last, first, m.	iddle)	·			2.	Employee or Social Security Number			
3. Organization					•				
P&C									
4.	T	ype of Leave/A	bsence			5. Family and Medical Leave			
Check appropriate box(es) and enter date and time below)	Da From	te To	From	Time To	Total Hours	If annual leave, sick leave, or leave without			
Accrued annual leave	FIOIII	10	FIOIII	10	-	pay will be used under the Family and			
Restored annual leave	······				1	Medical Leave Act of 1993 (FMLA), please provide the following information:			
Advance annual leave									
✓ Accrued sick leave	5/11/15	5/12/15	0800	1700	16.00	I hereby invoke my entitlement to family and medical leave for:			
Advance sick leave			<u>                                     </u>			Birth/Adoption/Foster care			
Purpose: Illness/injury/ii	ncapacitation of rec	wastina amalayaa				·			
	,		_1			Serious health condition of spouse, son, daughter, or parent			
	l/optical examination			of family mombor or		Conjugate houldboardiston of solf			
bereavement	member, monding	i mearcardemanop	lical examination (	of family member, or		Serious health condition of self			
Care of family	member with a se	rious health condition	on						
Other						Contact your supervisor and/or your personnel office to obtain additional			
		1		<del></del>	T	information about your entitlements and			
Compensatory time off						responsibilities under the FMLA. Medical certification of a serious health condition			
Other paid absence (specify in remarks)	<del></del>					may be required by your agency.			
Leave without pay									
6. Remarks (5.6)	c.l.				•				
•	•								
(3. 1	of Air								
						ed. I understand that I must comply with my			
						ional documentation, including medical r disciplinary action, including removal.			
7a.					9,04,140,10	7b. Date signed			
/a.						13 MAY 15			
8a. Official action on red	nucet				45.4				
oa. Official action of fed	luesi	Approv	ed	Disapproved		oproved, give reason. If annual leave, action to reschedule.)			
8b. Reason for disappro	oval				nni di di				
0.00	$\cap$		^			Tod Date signal			
8c. Signature						8d. Date signed			
						13 MAY (5			
Privacy Act Statement						1			
Section 6311 of title 5, l	Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by								
management and your Department of Labor wi	payroll office to hen processin	o approve and i g a claim for co	record your us ompensation	se ot leave. Addi regarding a iob	monal disclo	sures of the information may be: To the njury or illness; to a State unemployment			
compensation office re	garding a clain	n; to Federal Li	ife insurance (	or Health Benefi	its carriers re	egarding a claim; to a Federal, State, or			

local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federa agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.

		Request	for Leave	or Approv	ed Absei	nce
1. Name (Last, first, m	iddle)	_			2.	Employee or Social Security Number
3. Organization						
•						
P&C					. <u>.</u>	
4.	Ty	5. Family and Medical Leave				
Check appropriate box(es) and enter date and time below)			Total Hours	If annual leave, sick leave, or leave without		
Accrued annual leave	From 4/14/15	4/14/15	4.00	pay will be used under the Family and		
Restored annual leave	4/14/15	4/16/15	8.00	Medical Leave Act of 1993 (FMLA), please		
Advance annual leave	47 107 13		0800	10.00	provide the following information:	
Accrued sick leave				I hereby invoke my entitlement to family and medical leave for:		
Advance sick leave			· ·			
_				•	•	Birth/Adoption/Foster care
	ncapacitation of req					Serious health condition of spouse, son, daughter, or parent
_	l/optical examinatio		•			
Care of family bereavement	member, including	medical/dental/opt	ical examination of	family member, or		Serious health condition of self
Care of family	member with a se	rious health conditio	n			
Other						Contact your supervisor and/or your
						personnel office to obtain additional information about your entitlements and
Compensatory time off						responsibilities under the FMLA. Medical
Other paid absence						certification of a serious health condition may be required by your agency.
(specify in remarks)				<del>                                     </del>		
Leave without pay			<u> </u>	<u> </u>	<u> </u>	
6. Remarks						
employing agency's	procedures for	requesting lea	ave/approved a	absence (and p	rovide additi	d. I understand that I must comply with my onal documentation, including medical clisciplinary action, including removal.
7a, E					.	7b. Date signed
'						4/20/15
	· .		Į.			(120/13
8a. Official action on rec	quest	✓ Approve	ed	Disapproved		proved, give reason. If annual leave, action to reschedule.)
8b. Reason for disappro	oval					
8c. Signatu						8d. Date signed
oo. Signatu						ou. Date signed
						4/20/15
Privacy Act Statement	Initad States C	edo authoriza	a collection of	this information	. The prime	ry use of this information is by

		Pogues	t for Look	0 au Anna	arad Ala						
4. Name // and First in	tatau a	reques	Tior Leave	e or Appro							
1. Name (Last, first, m.	iaaie)				1	2. Employee or Social Security Number					
O Omeniantina		<u></u>									
3. Organization											
MCCS P&C											
4.	Т	ype of Leavel	Absence			5. Family and Medical Leave					
Check appropriate box(es) and enter date and time below)			ş	Time	Total Ho	fannual leave, sick leave, or leave without					
✓ Accrued annual leave	From 3/18/15	3/18/15	From 0900	1700	7.00	pay will be used under the Family and					
Restored annual leave	0,10,10	0,10,10		1	7.00	Medical Leave Act of 1993 (FMLA), please provide the following information:					
Advance annual leave			<u> </u>								
Accrued sick leave		I hereby invoke my entitlement to family and medical leave for:									
Advance sick leave		Birth/Adoption/Foster care									
Purpose: Illness/injury/incapacitation of requesting employee											
Medical/dental/optical examination of requesting employee											
Care of family member, including medical/dental/optical examination of family member, or Serious health condition of self											
bereavement	biith		W								
: <u> </u>	member with a se	enous nealm cond	IUOI1			Contact your supervisor and/or your					
Other						personnel office to obtain additional					
Compensatory time off			1			information about your entitlements and responsibilities under the FMLA. Medical					
Other paid absence		<u> </u>				<ul> <li>certification of a serious health condition may be required by your agency.</li> </ul>					
(specify in remarks)											
Leave without pay		<u> </u>	<u>.l</u>								
6. Remarks											
Dental Sick Ca	ll (complica	itions from	previous to	oth extracti	ion)	•					
7. Certification: I certify	that the leave	/absence req	uested above i eave/annroved	s for the purpo absence (and	se(s) indic i provide ac	ated. I understand that I must comply with my ditional documentation, including medical					
						s for disciplinary action, including removal.					
7a.				•		7b. Date signed					
						3/10/15					
8a. Official action on rec	ruget				45 -4	1 3 ( 7 / 7 )					
Ga. Official action of fee	quest	X Appro	ved [	Disapprov		sapproved, give reason. If annual leave, ate action to reschedule.)					
8b. Reason for disappr	oval			· · · · · ·							
Ro Cianatura						8d. Date signed					
8c. Signature						_					
						3/19/15					
Privacy Act Statement						( )					
Section 6311 of title 5.	United States	Code, authoria	zes collection o	of this informati	ion. The pr	imary use of this information is by					
Department of Labor w	hen processin	g a claim for	compensation	regarding a jol	b connecte	closures of the information may be: To the dinjury or illness; to a State unemployment					
compensation office re	garding a clair	n; to Federal I	Life Insurance	or Health Bene	efits carrie	rs regarding a claim; to a Federal, State, or violation of civil or criminal law; to a Federal					
agency when conducting	ng an investiga	ition for emplo	yment or secu	rity reasons; to	o the Office	of Personnel Management or the General					
Accounting Office when connection with its resp	the information	on is required	for evaluation	of leave admin	istration; c	r the General Services Administration in					
· ·			_								
Public Law 104-134 (A	pril 26, 1996) r ition number	equires that a This is an am	iny person doir endment to title	ng business wi e 31. Section 7	ith the Fed 701. Furni	eral Government furnish a social security shing the social security number, as well as					
other data, is voluntary.	but failure to d	io so may del	ay or prevent a	ction on the ap	plication. I	f your agency uses the information furnished					
on this form for purpos	es otner than t	nose indicate	a above, it may	y proviae you w	nın an add	tional statement reflecting those purposes.					

Office of Personnel Management 5 CFR 630

	<del></del>											
Request for Leave or Approved Absence												
1. Name (Last, first, m	iddle)			<u>.</u>	2.	Employee or Social Security Number						
3. Organization				~~···								
MCCS P&C												
4.	O. I annily and triedical Leave											
Check appropriate box(es) and enter date and time below)		<u> </u>		Time To	Total Hours	If annual leave, sick leave, or leave withou						
Accrued annual leave	3/16/15	3/17/15	From 1400	11.00	pay will be used under the Family and							
Restored annual leave	0710710	3, 11, 10		Medical Leave Act of 1993 (FMLA), please provide the following information:								
Advance annual leave			<u> </u>			1						
✓ Accrued sick leave	3/16/15	4.00	I hereby invoke my entitlement to family and medical leave for:									
Advance sick leave						Birth/Adoption/Foster care						
Purpose: 🗸 Illness/injury/ii	ncapacitation of rec	questing employee				Serious health condition of						
Purpose: Illness/injury/incapacitation of requesting employee  Serious health condition of spouse, son, daughter, or parent												
Care of family member, including medical/dental/optical examination of family member, or bereavement  Serious health condition of self												
	member with a se	erious health condit	ion			_						
Other						Contact your supervisor and/or your						
						personnel office to obtain additional information about your entitlements and						
Compensatory time off						responsibilities under the FMLA. Medical certification of a serious health condition						
Other paid absence (specify in remarks)						may be required by your agency.						
Leave without pay												
6. Remarks		· · · · · · · · · · · · · · · · · · ·			<del></del>							
Dental Sick Cal	ll (Remove	d teeth)										
	· · · · · · · · · · · · · · · · · · ·											
						d. I understand that I must comply with my						
						ional documentation, including medical r disciplinary action, including removal.						
7a. Er						7b. Date signed						
ra. Li						3/18/15						
8a. Official action on red	nuest				(IF alia a							
ou. Omolar addon on roc	14001	Approv	/ed [	Disapprove	-(1 ' '	oproved, give reason. If annual leave, action to reschedule.)						
8b. Reason for disappro	oval	····										
8c. Signature				·		8d. Date signed						
						-101.						
		03/18/15										
Privacy Act Statement		Code authoriz	es collection o	of this information	on The prima	ary use of this information is by						
management and your	payroll office to	o approve and	record your us	se of leave. Add	ditional disclo	sures of the information may be: To the						
						njury or illness; to a State unemployment egarding a claim; to a Federal, State, or						
local law enforcement a	agency when v	our agency be	comes aware	of a violation o	r possible vid	plation of civil or criminal law; to a Federal Personnel Management or the General						
Accounting Office when	the information	on is required t	for evaluation of	of leave admini	stration; or th	e General Services Administration in						
connection with its resp	onsibilities fo	r records man	agement.									
Public Law 104-134 (Applied	oril 26, 1996) r	equires that a	ny person doir	ng business wi	th the Federa	ll Government furnish a social security ng the social security number, as well as						
other data, is voluntary,	but failure to c	io so may dela	y or prevent a	ction on the app	plication. If yo	our agency uses the information furnished						
on this form for purpose	es other than t	hose indicated	d above, it may	y provide you wi	ith an additio	nal statement reflecting those purposes.						

			Request	for Leave	or Approv	ed Abse	nce				
1.	Name (Last, first, m	iddle)			• • •	2.	Employee or Social Security Number				
·											
3.	Organization										
	MCCS P&C						•				
4.		T	ype of Leave/A	bsence			5. Family and Medical Leave				
	eck appropriate box(es) and er date and time below)	Da From	te I To		ime To	Total Hours	If annual leave, sick leave, or leave without				
	Accrued annual leave	FIOIII	10	From	10		pay will be used under the Family and . Medical Leave Act of 1993 (FMLA), please				
	Restored annual leave						provide the following information:				
	Advance annual leave		3/2/15		I hereby invoke my entitlement						
	Accrued sick leave	3/2/15	8.00	to family and medical leave for:							
L	Advance sick leave			Birth/Adoption/Foster care							
Purpose: Illiness/injury/incapacitation of requesting employee											
Medical/dental/optical examination of requesting employee											
	Care of family bereavement	member, including	medical/dental/opti	ical examination of	family member, or		Serious health condition of self				
	Care of family	member with a se	rious health conditio	חת			•				
	Other						Contact your supervisor and/or your				
		<del>,</del>	<del> </del>	····		<del></del>	personnel office to obtain additional information about your entitlements and				
	Compensatory time off						responsibilities under the FMLA. Medical certification of a serious health condition				
	Other paid absence (specify in remarks)					<u> </u>	may be required by your agency.				
	Leave without pay										
6.	Remarks										
				<u>.</u>							
							ed. I understand that I must comply with my				
							tional documentation, including medical or disciplinary action, including removal.				
7a.						<u> </u>	7b. Date signed				
, u.							3/3/15				
8a	Official Getion on red	illest			_	/IE al:	annual also access if annual leave				
Ou.	omolar abilon on rec	14001	Approve	ed _	Disapproved	1 '	pproved, give reason. If annual leave, action to reschedule.)				
8b.	Reason for disappro	oval				<del></del>					
8c.	Signature						8d. Date signed				
							n 11. 1.				
	<u>.</u>					•	3/10/15				
Pri Se	vacy Act S	Inited States C	Code authorize	s collection of	this informatio	] n. The ໝim	ary use of this information is by				
ma	nagement and your	payroll office to	approve and r	ecord your use	e of leave. Addi	tional discl	osures of the information may be: To the injury or illness; to a State unemployment				
CO	mpensation office re-	garding a clain	n; to Federal Lit	fe insurance o	r Health Benefi	ts carriers i	egarding a claim; to a Federal, State, or				
loc	al law enforcement a	agency when you	our agency bed tion for employ	comes aware of ment or securi	of a violation or tv reasons: to t	possible vi he Office of	olation of civil or criminal law; to a Federal Personnel Management or the General				
Ac	counting Office when	the informatio	n is required fo	or evaluation of	fleave adminis	tration; or ti	ne General Services Administration in				
	nnection with its resp			_							
nu	mber or tax identifica	tion number. T	his is an amer	ndment to title	31, Section 770	01. Furnishi	al Government furnish a social security ing the social security number, as well as				
oth	ner data, is voluntary,	but failure to d	o so may delay	or prevent ac	tion on the app	lication. If y	our agency uses the information furnished nal statement reflecting those purposes.				
UII	ma form for purposi	sa outer utan u	nose mulcaleu	above, it iliay	Provide you will	a addide	otatomont roneoung those purposes.				

Request for Leave or Approved Absence											
1. Name (Last, first, m	iddle)					Employee or Social Security Number					
3. Organization											
MCCS P&C											
4.	T	ype of Leave/A	bsence			5. Family and Medical Leave					
Check appropriate box(es) and enter date and time below)	Da From	te	From	ime	Total Hours	If annual leave, sick leave, or leave without					
Accrued annual leave	2/2/15	2/2/15	0900	1200	3.00	pay will be used under the Family and					
Restored annual leave						Medical Leave Act of 1993 (FMLA), please provide the following information:					
Advance annual leave											
✓ Accrued sick leave	2/2/15	4.00	I hereby invoke my entitlement to family and medical leave for:								
Advance sick leave	<u> </u>		Birth/Adoption/Foster care								
Purpose: ✓ Illness/injury/incapacitation of requesting employee											
Medical/dental/optical examination of requesting employee  Medical/dental/optical examination of requesting employee  Serious health condition of spouse, son, daughter, or parent											
Care of family member, including medical/dental/optical examination of family member, or bereavement  Serious health condition of self											
l —	member with a se	rious health conditio	nn			_					
Other	momber mar a co	NOTO NOTICE	,,,			Contact your supervisor and/or your					
						personnel office to obtain additional information about your entitlements and					
Compensatory time off						responsibilities under the FMLA. Medical certification of a serious health condition					
Other paid absence (specify in remarks)						may be required by your agency.					
Leave without pay											
6. Remarks											
Went home wit	h fever.										
						d. I understand that I must comply with my					
						ional documentation, including medical disciplinary action, including removal.					
7a. Emp				•		7b. Date signed					
						2/2/15					
8a. Official action on red	uest	ļum-ja		<del></del>	(If disar	proved, give reason. If annual leave,					
	•	Approve	ed L	_ Disapproved		action to reschedule.)					
8b. Reason for disappr	ovai	·									
	_	^									
8c. Signature			,,			8d. Date signed					
						02					
						03/03/15					
Privacy Act Statement Section 6311 of title 5. I		ode. authorize	s collection of	this information	n. The prima	ry use of this information is by					
management and your	payroll office to	approve and r	ecord your use	of leave. Addit	ional disclo	sures of the information may be: To the njury or illness; to a State unemployment					
compensation office re	garding a clain	i; to Federal Lif	fe İnsurance oı	r Health Benefit	s carriers re	egarding a claim; to a Federal, State, or					
agency when conducting	g an investigat	tion for employ	ment or securit	ty reasons; to th	ne Office of I	lation of civil or criminal law; to a Federal Personnel Management or the General					
Accounting Office when connection with its resp	the informatio	n is required fo	r evaluation of	leave administ	ration; or th	e General Services Administration in					
				. 1	41 1	O					
Public Law 104-134 (A) number or tax identifica	oril 26, 1996) re tion number. T	equires that any his is an amer	y person doing idment to title :	ุ pusiness with 31, Section 770	tne Federa 1. Furnishir	Government furnish a social security  ng the social security number, as well as					
other data, is voluntary,	but failure to d	o so may delay	or prevent act	ion on the appli	ication. If yo	ur agency uses the information furnished					

Office of Personnel Management 5 CFR 630

Request for Leave or Approved Absence											
1. Name (Last, first, mi	iddle)	-	··=·		2.	Employee or Social Security Number					
	,										
3. Organization		<u> </u>									
MCCS P&C											
4. Type of Leave/Absence 5. Family and Medical Leave  Check appropriate box(es) and Date Time Table 15. The Date To the Control of the Contro											
Check appropriate box(es) and enter date and time below)	If annual leave, sick leave, or leave without										
Accrued annual leave	From	То	<del> </del>	pay will be used under the Family and							
Restored annual leave		Medical Leave Act of 1993 (FMLA), please provide the following information:									
Advance annual leave			provide the lonowing information.								
Accrued sick leave I I hereby invoke my entitlement to family and medical leave for:											
Advance sick leave						Birth/Adoption/Foster care					
Purpose: Illness/injury/ir	ncapacitation of req	uesting employee				Serious health condition of					
Medical/denta	l/optical examination	n of requesting emp	olovee			spouse, son, daughter, or parent					
Care of family	•		•	family member, or		Serious health condition of self					
bereavement  Caro of family	member with a se	rique haalth conditio	ND.								
Other	Thember with a se.	nous near condition	R1			Contact your supervisor and/or your					
Office						personnel office to obtain additional					
Compensatory time off		**************************************				information about your entitlements and responsibilities under the FMLA. Medical certification of a serious health condition					
Other paid absence (specify in remarks)	·				·	may be required by your agency.					
Leave without pay	1/22/15	1/22/15	0800	700	8.00						
6. Remarks					!						
						-					
employing agency's	procedures for	requesting lea	ave/approved a	absence (and p	rovide addit	d. I understand that I must comply with my ional documentation, including medical rdisciplinary action, including removal.					
7a. En	<u> </u>					7b. Date signed					
						1/21/15					
8a. Official action on red	quest	∠ Approve	ed	Disapproved	, , ,	oproved, give reason. If annual leave, action to reschedule.)					
8b. Reason for disappro	oval										
8c. Signature						8d. Date signed					
				-		21 JAN 15					
management and your Department of Labor will compensation office relical law enforcement agency when conductin Accounting Office when connection with its respondent Law 104-134 (Ar	Jnited States C payroll office to hen processing garding a claim agency when you g an investigat the information ponsibilities for pril 26, 1996) re	approve and r g a claim for co n; to Federal Lit our agency bection for employ n is required for records mana	record your use ompensation re fe Insurance o comes aware o ment or securior or evaluation of gement.	e of leave. Addi egarding a job r Health Benefi of a violation or ty reasons; to t f leave administ	tional disclo connected in ts carriers no possible vious the Office of tration; or the	ary use of this information is by sures of the information may be: To the njury or illness; to a State unemployment egarding a claim; to a Federal, State, or olation of civil or criminal law; to a Federal Personnel Management or the General e General Services Administration in					
other data, is voluntary,	but failure to d	o so may delay	or prevent act	tion on the appl	lication. If yo	our agency uses the information furnished nal statement reflecting those purposes.					

Office of Personnel Management

5 CFR 630

			Reques	t for Leave	e or Appro	ved Abse	nce				
1.	Name (Last, first, mi	iddle)				2.	Employee or Social Security Number				
3.	Organization										
	MCCS P&C				,						
4.		Ty	pe of Leave/A	bsence			5. Family and Medical Leave				
	eck appropriate box(es) and er date and time below)			If annual leave, sick leave, or leave without							
	Accrued annual leave	From 1/15/15	To 1/15/15	Total Hours	pay will be used under the Family and						
Ë	Restored annual leave	1/10/10	1710/10	1300	Medical Leave Act of 1993 (FMLA), please provide the following information:						
	Advance annual leave					<u> </u>					
V	Accrued sick leave	1/15/15	1.00	I hereby invoke my entitlement to family and medical leave for:							
	Advance sick leave			Birth/Adoption/Foster care							
Pu	Purpose: Illness/injury/incapacitation of requesting employee										
	Medical/dental	Voptical examinatio	n of requesting em	plovee			spouse, son, daughter, or parent				
	Care of family member, including medical/dental/optical examination of family member, or										
	bereavement'		dava baalik aandii								
	Other	member with a se	nous neam condid	ОП			Contact your supervisor and/or your				
	Other						personnel office to obtain additional				
Г	Compensatory time off	1				$\top$	information about your entitlements and responsibilities under the FMLA. Medical				
	Other paid absence						certification of a serious health condition may be required by your agency.				
	(specify in remarks)	1/15/15	1/16/15	4500	1700	40.00	may so roquirou sy your agonoy.				
	Louve Williout pay	1/10/10	1/10/13	1500	1700	10.00					
о.	Remarks										
	Infant son had f	ever. Need	ded to go h	ome to mo	nitor.		:				
7	0-45-411	that the language	<u></u>		- for the answer		d 1 d				
							d. I understand that I must comply with my ional documentation, including medical				
							disciplinary action, including removal.				
7a.	E				<del></del>		7b. Date signed				
	4						1/19/15				
8a.	Official action on rec	uest	<u> </u>			. (If disar	proved, give reason. If annual leave,				
			Approv	ed [	Disapprove		action to reschedule.)				
8b.	Reason for disappro	oval									
			_								
8c.	Signature						8d. Date signed				
							· ·				
							19 JAN 15				
Pri	vacy Act Statement	1-4-4 04-4 0	\d		filmin informaci	ian Thansina	af this information is bu				

Request for Leave or Approved Absence												
1. Name (Last, first, ma	iddle)				2.	Employee or Social Security Number						
3. Organization		!										
MCCS P&C												
4.	T	ype of Leave/A	bsence			5. Family and Medical Leave						
Check appropriate box(es) and enter date and time below)				Time	Total Hours	If annual leave, sick leave, or leave without						
✓ Accrued annual leave	From 1/14/15	To 1/14/15	From 0800	To 1700	8.00	pay will be used under the Family and Medical Leave Act of 1993 (FMLA), please						
Restored annual leave			ļ	provide the following information:								
Advance annual leave	rued sick leave I I hereby invoke my entitlement to family and medical leave for:											
Advance sick leave												
		Birth/Adoption/Foster care										
Purpose: Illness/injury/incapacitation of requesting employee  Medical/dental/optical examination of requesting employee  Medical/dental/optical examination of requesting employee  Serious health condition of spouse, son, daughter, or parent												
	•	, .	• •	family member, or	•	Serious health condition of self						
Posterna	member with a se	rious health condition	on									
Other						Contact your supervisor and/or your						
						personnel office to obtain additional information about your entitlements and						
Compensatory time off						responsibilities under the FMLA. Medical certification of a serious health condition						
Other paid absence (specify in remarks)						may be required by your agency.						
Leave without pay				-								
						ed. I understand that I must comply with my tional documentation, including medical						
						r disciplinary action, including removal.						
7a. Emplo		, <u> </u>				7b. Date signed //15/15						
8a. Officiar action of rec	<sub>quest</sub>	Y Approve	ed	Disapproved	1 ' '	oproved, give reason. If annual leave, action to reschedule.)						
8b. Reason for disappro	oval											
8c. Signature				ľ		8d. Date signed						
						01/15/15						
Privacy Act Statement						1 2 1 1 1 1 1						
Section 6311 of title 5, I management and your Department of Labor will compensation office relocal law enforcement agency when conductin Accounting Office when connection with its responded.	United States C payroll office to hen processing garding a clain agency when y ig an investiga the informatio consibilities for poril 26, 1996) re	o approve and of a claim for continuous and the continuous agency bed tion for employ on is required for records manal aguires that an aguires that an agency and the continuous aguires that an agency and the continuous aguires that an aguires agu	record your us ompensation reference comments aware of the comment or securion or evaluation or evaluation or evaluation or expensive comment.	e of leave. Addi egarding a job or Health Benefi of a violation or ity reasons; to t f leave administ g business with	itional disclo connected i its carriers r possible vio the Office of tration; or the	ary use of this information is by sures of the information may be: To the njury or illness; to a State unemployment egarding a claim; to a Federal, State, or olation of civil or criminal law; to a Federal Personnel Management or the General se General Services Administration in						
number or tax identifica other data, is voluntary,	ition number. T but failure to d	This is an amei lo so may delay	ndment to title y or prevent ac	31, Section 770 tion on the appl	01. Furnishi lication. If yo	ng the social security number, as well as our agency uses the information furnished nal statement reflecting those purposes.						

Request for Leave or Approved Absence												
1. Name (Last, first, mi	ddle)	-			2.	Employee or Social Security Number						
3. Organization			7.55									
MCCS P&C												
4.	O. Talling are mouted 2007											
Check appropriate box(es) and enter date and time below)		te To	Total Hou	s If annual leave, sick leave, or leave without								
✓ Accrued annual leave	1/13/15	1/13/15	From 0800	1200	4.00	pay will be used under the Family and Medical Leave Act of 1993 (FMLA), please						
Advance annual leave		<u> </u>		<del>                                     </del>		provide the following information:						
✓ Accrued sick leave	1/13/15	1/13/15	4.00	I hereby invoke my entitlement to family and medical leave for:								
Advance sick leave						7 <b>_</b> _ ·						
Purpose: Illness/injury/incapacitation of requesting employee  Medical/dental/optical examination of requesting employee  Care of family member, including medical/dental/optical examination of family member, or bereavement  Birth/Adoption/Foster care  Serious health condition of spouse, son, daughter, or parent spouse, son, daughter, or parent spouse spouse, son, daughter, or parent spouse s												
Care of family	member with a se	rious health conditio	ก									
Other						Contact your supervisor and/or your personnel office to obtain additional information about your entitlements and						
Compensatory time off						responsibilities under the FMLA. Medical certification of a serious health condition						
Other paid absence (specify in remarks)						may be required by your agency.						
Leave without pay			,	]								
employing agency's	procedures for	requesting lea	ve/approved a	bsence (and pr	rovide add	ted. I understand that I must comply with my itional documentation, including medical or disciplinary action, including removal.						
7a. Emplo	^ -					7b. Date signed						
8a. Official action on rec	quest	Approve	ed [	Disapproved		approved, give reason. If annual leave, e action to reschedule.)						
8b. Reason for disappro	oval	ſ										
8c. Signature						8d. Date signed						
management and your Department of Labor will compensation office relocal law enforcement agency when conductin Accounting Office when connection with its responded by the context of the	Jnited States C payroll office to hen processing garding a claim agency when yig g an investigat the informatio consibilities for oril 26, 1996) re titon number. T but failure to d	approve and rig a claim for con; to Federal Litour agency bection for employ in its required for records manal equires that any his is an amerio so may delay	record your use ompensation refe Insurance or comes aware or ment or security or evaluation of gement. y person doing adment to title of	e of leave. Additegarding a job or Health Benefit fa violation or by reasons; to the leave administ business with 31, Section 770 fon on the application on the application of the section of the application of the applicati	tional disc connected ts carriers possible value Office of tration; or the Fede of Furnishication. If	nary use of this information is by losures of the information may be: To the injury or illness; to a State unemployment regarding a claim; to a Federal, State, or riolation of civil or criminal law; to a Federal of Personnel Management or the General the General Services Administration in ral Government furnish a social security ring the social security number, as well as your agency uses the information furnished onal statement reflecting those purposes.						

Employee 3D. Departments    Horizon   Communication   Communic	IWAKUNI MCCS MARINE CORPS COMMUNIT PERSONNEL OFFICER FPO AP, 96310-1867	TY SERVICES, ATTN	Pay Gi IWM-Iw Pay Begui Date: 12/27/20 Pay End Date: 01/09/20		ess Unit: AL.ICE #: Advice Date:	SP145 000000004008510 01/15/2016	,
Description   Current   Field   Current   Cu		Departme Job Title Business	ent: 446919-PURCHASING/ : Title:	CONTRAC	Marital Status: Allowances: Addl. Percent:	Married	
Description		но	URS AND EARNINGS	<del> </del>		TAXES	<del></del> :
DESCRIBER ASTER LAX DEDUCTIONS  ASTER TAX DEDUCTIONS  ASSERT TOTAL  ASSERT TAX DEDUCTIONS  ASSERT TOTAL TAX DEDUCTIONS  ASSERT TOTAL TAX DEDUCTIONS  ASSERT TOTAL DEDUCTIONS  ASSERT TOTAL DEDUCTIONS  NET PAY DISTRIBUTION  ADVANCED TO A Adjustments  ASSERT TAX DEDUCTIONS  ASSERT TAX DESCRIPTIONS  ASSERT TAX DEDUCTIONS  ASSERT TAX DEDUCTIONS  ASSERT TAX DEDUCTIONS  ASSE	Admin Hours, No Diff Holiday Hours (not worked), No Leave Without Pay Sick Hours, No Diff Vacation Hours, No Diff Regular Hours, No Diff		Hours Earnines 4.00 8.00 1.25 2.50 5.75 57.50	Hours 4.00 8.00 1.25 2.50 5.75 57.50	Fed Withholding Fed MED/EE	Current	vr
Description   Current   VTD   Description   Current   Current   Current   VTD   Description   Current	TOTAL:						
Actina US Health Care Tradil Actina US Health	BEFORE-TAX	DEDUCTIONS	AFTE	R-TAX DEDUCTIONS	E	MPLOYER COST OF BENEFI	TS
Plan) are deposited toward the collective finding level of the roll and and are not attributable to individual condicional accounts   TOTAL GROSS	Aetna US Health Care Tradtl Aetna US Health Care Dental	Current	Unicare Supplemental L Unicare Standard Life Opt Dependent Life 4 NAF Pension Plan Disability Short Term 401k Loan Payback		YTD Description Aetna US Health Aetna US Health Unicare Standar 401(k) NAF Retirement Fed Med/ER	Care Tradil I Care Dental I Life	
TOTAL GROSS	TOTAL				plan) are deposi	ted toward the collective funding I	level of the
Leave Plans	IUIAL:	TOTAL CROSS	EED TAVABLE CROSS	TOTAL TAVE	c TOTAL DE	DUCTIONS	NIEST D
Leave Plans		TOTAL GROSS	PED TAXABLE GROSS	TOTAL TAXE	5 IOTAL DE	DOCTIONS	NEI VA
MESSAGE:  IWAKUNI MCCS  MARINE CORPS COMMUNITY SERVICES ATTN PERSONNEL OFFICER FPO AP, 96310-1867  Deposit Amount:  To The	Leave Plans Prior Vacation Sick Comp Time Cmp Tr Lv	6.0 9.8 4.0 3.9 1.0 0.0	9.8 5.8 3.9 2.5	5.8 2.5	10.1 Che 5.4 0.0 0.0		TION
IWAKUNI MCCS MARINE CORPS COMMUNITY SERVICES ATTN PERSONNEL OFFICER FPO AP, 96310-1867  Deposit Amount:  To The					тот	AL:	
To The	IWAKUNI MCCS MARINE CORPS COM SERVICES ATTN PERSONNEL O		Date: 01.	/15/2016	Advice No. 40	08510	
	To The						

NON-NEGOTIABLE

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IWAKUNI MCCS MARINE CORPS COMMUNITY SERV PERSONNEL OFFICER FPO AP, 96310-1867	ICES, ATTN	Pay G. Pay Begin Date: Pay End Date:	IWM-Iwak 12/13/2015 12/26/2015	i	-	بد	Advice #: Advice Date:	SP145 000000003996654 12/31/2015		
			···	<del></del>			TAX DATA:	Federa	<u> </u>	****
	Employee 1	D:					Marital Status:	годета Матте		WA State
<u> </u>	Departmen	: 446919-P	URCHASING/CO	ONTRAC			Allowances:		2	n/a
·	Job Title:							•	4	0
	Business T	tle:					Addl. Percent:			
	Pay Rate:						Addl. Amount:			
	нои	RS AND EARNI	NGŞ					TAXES		
Description	Data	Current	Paret		YTD -		Danaulatian		S	* Imp
Comp Leave Earned	Rate	<u>Hours</u> 1.00	<u>Earnings</u>	Hours		<u>Earnings</u>	Description Fed Withholdn	_	Current	YTD
Holiday Hours (not worked), No		12.00		1.00 100.00			Fed MED/EE	B		
Leave Without Pay		0.09		62.32			Fed OASDI/EI	7		
Sick Hours, No Diff		3.16		104.37			1 CG ONSDIEL	•		
Vacation Hours, No Diff		4.75		160.81						
Regular Hours, No Diff		60.00		1,721.50						
Admin Hours, No Diff		00.00		3.00						
AWOL-Absent w/o Official				8.00						
Leave				5.00						
Comp Leave Taken, No Diff										
•										
TOTAL:										
BEFORE-TAX DEDUC				TAX DEDU				EMPLOYER COST O		
	<u>Current</u>	YTD Descript			Current	<u>YTD</u>	<u>Description</u>		Current	<u>YTD</u>
Aetna US Health Care Tradtl			Supplemental Life	:			Aeina US Heal		•	
Aetna US Health Care Dental			Standard Life				Aetna US Heal			
401(k)			endent Life 4				Unicare Standa	ird Life		
			sion Plan				401(k)	nt (Group Benefit)		
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		ŀ					l ca onobbel			
								<del></del>		
								tributions to the NAF Re		
							plan) are depo	sited toward the collecti	ve funding level of	the
TOTAL:							plan and are n	ot attributable to individ	uai participant acc	ounts.
	GROSS	FED TAXABLE	CDOSS	7	TOTAL TAXE	•	TOTAL D	EDUCTIONS		NET PAY
Current		TED INTURBIE	JACOBO		O IAL IAAL		TOTALD			, 122 4 4 5 1
YTD										
Leave Plans Prior Yr Bal	*Earn PPD				Adjustments	End Bal	UseLose		ISTRIBUTION	
Vacation 12.1	6.0	154.7	4.8	160.8		6.0	Ch	ecking XXXXX6705		
Sick 7.9	4.0	100.5	3.2	104.4		4.0	k			
Comp Time 0.0	0.1	1.0				1.0 0.0	ı			
Cmp Tr Lv 0.0						0.0	1			
Time Off 0.0						0.0				
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			·				[ro	TAL:		
MESSAGE:										
4,200,100,				•						

IWAKUNI MCCS MARINE CORPS COMMUNITY SERVICES ATTN PERSONNEL OFFICER FPO AP, 96310-1867

Date: 12/31/2015

Advice No. 3996654

Deposit Amount:

To The Account(s) Of



IWAKUNI MCCS MARINE CORPS COMMUNITY SEI PERSONNEL OFFICER FPO AP, 96310-1867	RVICES, ATTN	Pay C. p: Pay Begin Date Pay End Date:	IWM-Iwaki : 11/29/2015 12/12/2015	ini MCCS		·	ness Unit: Advice #: Advice Date:	SP145 0000000039847 12/18/2015	20	
	Employee Departmer Job Title: Business T Pay Rate:	nt: 446919-	PURCHASING/CO	NTRAC			TAX DATA: Marital Status: Allowances: Addl. Percent; Addl. Amount			WA Stat
	но	JRS AND EARN	INGS					TAX	28	
Description Leave Without Pay Sick Hours, No Diff Vacation Hours, No Diff Regular Hours, No Diff Admin Hours, No Diff AWOL-Absent w/o Official Leave Comp Leave Earned Holiday Hours (not worked), No Comp Leave Taken, No Diff	Rate	- Current	Earnings	Hours 62.23 101.21 156.06 1,661.50 3.00 8.00	YTD	Earnings	<u>Description</u> Fed Withholds Fed MED/EE Fed OASDI/E	ng	Current	УТ
TOTAL:										
BEFORE-TAX DEDU  Description Aetna US Health Care Tradtl Aetna US Health Care Dental 401(k)	JCTIONS Current	Unicare Opt Dep NAF Pe 401k Lo		FAX DEDUCT	TONS Current	УТО	Actna US Hea Unicare Stand 401(k) NAF Retiremo Fed Med/ER Fed OASDI/E	ent (Group Benefit)	Current  Current	
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TOTAL:			7.0000		m. r m. 1770		mom. v n	Thursday ONG		NIEW DA
Current YTD	AL GROSS	FED TAXABL	EGROSS	10	TAL TAXES	5	TOTALL	DEDUCTIONS		NET PA
Leave Plans         Prior Yr Br           Vacation         12.           Sick         7.           Comp Time         0.           Cmp Tr Lv         0.           Time Off         0.	1 4.7 9 3.2 0 0	Earn YTD 3 148.7 96.5	Taken PPD Tak 4.3 2.9	ten YTD Ad 156.1 101.2	justments	End Bal 4.8 3.2 0.0 0.0 0.0		NET PA) Hecking XXXXX670  DTAL:	Y DISTRIBUTION 5	
MESSAGE:										
IWAKUNI MCCS MARINE CORPS COMMUNISERVICES ATTN PERSONNEL OFFIC FPO AP, 96310-1867			Date: 12/18	3/2015		A	advice No. 3	<b>3984720</b>		
Deposit Amount:										
To The										

NON-NEGOTIABLE

Location: PURCHASING/CONTRAC

Account(s) Of

IWAKUNI MCCS MARINE CORPS COMMUNITY SERVICES, ATTN PERSONNEL OFFICER FPO AP, 96310-1867	Pay C ,: Pay Begin Date: Pay End Date:	IWM-Iwal 11/15/201: 11/28/201:				.ness Unit: Advice #: Advice Date:	SP145 000000003970388 12/04/2015	es.	
Employee Departm Job Titles Business Pay Rate:	ent: 446919-P1	URCHASING/C	ÓNTRAC			TAX DATA: Marital Status: Allowances: Addl. Percent: Addl. Amount:	Feders Marrie		WA State n/a 0
НО	URS AND EARNI	NGS					TAXES		
Description Rate  Admin Hours, No Diff  Holiday Hours (not worked), No Leave Without Pay Sick Hours, No Diff Vacation Hours, No Diff Regular Hours, No Diff AWOL-Absent w/o Official Leave	Hours 1.00 8.00 22.01 3.99 6.00 39.00	Earnings 0.00	Hours 3.00 88.00 45.47 98.31 151.72 1,605.50 8.00			<u>Description</u> Fed Withholdn Fed MED/EE Fed OASDI/EI	•	Current	YTU
Comp Leave Earned Comp Leave Taken, No Diff	_	0.00 0.00			0.00 0.00				
TOTAL:						•			
BEFORE-TAX DEDUCTIONS			-TAX DEDUC				EMPLOYER COST O		
Description Current Aetna US Health Care Tradtl Aetna US Health Care Dental 401(k)	Unicare S Opt Depe NAF Pen 401k Loa	upplemental Life tandard Life ndent Life 4		Current	YTD	Unicare Standa 401(k)	ith Care Dental ard Life nt (Group Benefit)	Current	YTC
		***				plan) are depo	tributions to the NAF R sited toward the collect ot attributable to individ	ive funding level o	of the
TOTAL:									NIPO N
Current YTD	FED TAXABLE	GROSS		OTAL TAXES		TOTAL D	EDUCTIONS		NET PA
Leave Plans Prior Yr Bat *Earn PPD	Earn YTD *7	Taken PPD T	aken YTD /	Adjustments	End Bal	UseLose	NET PAY I	ISTRIBUTION	
Vacation         12.1         4.3           Sick         7.9         2.9           Comp Time         0.0         0           Cmp Tr Lv         0.0         0           Time Off         0.0         0	144.0	6.0 4.0	151.7 98.3		4.3 2.9 0.0 0.0 0.0		ecking XXXXX6705		
						TO	TAL:		

IWAKUNI MCCS
MARINE CORPS COMMUNITY
SERVICES
ATTN PERSONNEL OFFICER
FPO AP, 96310-1867

Date: 12/04/2015

Advice No. 3970388

Deposit Amount:

To The Account(s) Of



WANTEN MOOO					<del></del>						
IWAKUNI MCCS MARINE CORPS COMMUNI PERSONNEL OFFICER FPO AP, 96310-1867	TY SERVICES	, ATTN	Pay Los Pay Begin Date: Pay End Date:	IWM-Iwaku 11/01/2015 11/14/2015	ni MCCS	<b>ئ</b>	ţ	iness Unit: Advice #: Advice Date:	SP145 000000003958420 11/20/2015		
<del></del>	·····		<u> </u>	<del></del>				TAX DATA:	Federa	<del></del>	3774 54-4
		Employee	ID:					Marital Status:	Married		WA Stat
		Departmen	nt: 446919-PU	JRCHASING/CO	NTRAC			Allowances:	2		עו
		Job Title:						Addl. Percent:	•	•	,
		Business T Pay Rate:	Title:					Addl. Amount:			
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<u> </u>		юн	JRS AND EARNIN  - Current	IGS		— YTD			TAXES		
<u>Description</u> Holiday Hours (not worked), N Leave Without Pay	Ra o	te	Hours 8.00 0.07	Earnings	Hours 80.00 23.46		Earnings	Description Fed Withholding Fed MED/EE		Current	УT
Sick Hours, No Diff			4.00		94.32			Fed OASDI/EE			
Vacation Hours, No Diff			7.93		145.72						
Regular Hours, No Diff	-		60.00		1,566.50						
Admin Hours, No Diff					2.00				,		
AWOL-Absent w/o Official Leave					8.00						
Comp Leave Earned											
Comp Leave Taken, No Diff									•		
TOTAL:											
BEFORE-TAX					AX DEDUC				MPLOYER COST O		
Description	Curre	n <u>t</u>	YTD Descripti			Current	<u>YTD</u>	Description	C T 13	Current	YT
Aetna US Health Care Tradtl Aetna US Health Care Dental				upplemental Life tandard Life				Aetna US Health Aetna US Health			
401(k)				ndent Life 4				Unicare Standard			
401(k)			NAF Pens					401(k)	LIIC		
				Payback				NAF Retirement	(Group Benefit)		
			1012 200	11 dy Daoit				Fed Med/ER	(Group Denotity		
			İ					Fed OASDI/ER			
								plan) are deposit	butions to the NAF Re ed toward the collectivations at the attributable to individual	ve funding level	of the
TOTAL:								pian and are not	attributable to matria	um purnerpant a	ccounts.
	TOTAL GRO	oss	FED TAXABLE	GROSS	r	OTAL TAXES		TOTAL DEI	DUCTIONS		NET PA
Current	TOTALIGN	7.50	TED TAXABLE	GROSS		OTAL TABLES		TOTALDE	JOETTON B		11,22 11.
YTD											
		arn PPD				djustments	End Bal	UseLose		ISTRIBUTION	1
Vacation	12.1	6.0	139.6	7.9	145.7		6.0 4.0		king XXXXX6705		
Sick	7.9 0.0	4.0	90.4	4.0	94.3		0.0				
Comp Time Cmp Tr Lv	0.0						0.0				
Time Off	0.0						0.0				
								тот	AL:	<del></del>	
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MESSAGE:											
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				_				. 7.4. 37 60:	-0.420		
IWAKUNI MCCS				Date: 11/20	/2015		A	Advice No. 395	58420		
MARINE CORPS COM	MUNITY										
SERVICES											
ATTN PERSONNEL C	FFICER										
FPO AP. 96310-1867											

Deposit Amount:

To The Account(s) Of

IWAKUNI MCCS MARINE CORPS COMMUNITY SERVICES, AT PERSONNEL OFFICER FPO AP, 96310-1867	Pay 2: Pay Begin Dat Pay End Date:	IWM-Iwakun e: 10/18/2015 10/31/2015	i MCCS		iness Unit: Advice #: Advice Date:	SP145 00000003946402 11/06/2015	
De Joh Bu:	ployee ID: partment: 446919 Title: siness Title:	P-PURCHASING/CON	TRAC		TAX DATA: Marital Status: Allowances: Addl. Percent: Addl. Amount:	Federal Married 2	WA Stat
	HOURS AND EAR	NINGS				TAXES	
Description Sick Hours, No Diff Vacation Hours, No Diff Regular Hours, No Diff Admin Hours, No Diff AWOL-Absent w/o Official Leave Comp Leave Earned Holiday Hours (not worked), No Leave Without Pay Comp Leave Taken, No Diff	Current — Hours 3.97 4.03 72.00	Earnings	Hours 90.32 137.79 1,506.50 2.00 8.00 72.00	Earnines	Description Fed Withholding Fed MED/EE Fed OASDI/EE	Current	УП
TOTAL:							
Description Aetna US Health Care Tradtl Aetna US Health Care Dental 401(k)	Unicar Opt Do NAF F		X DEDUCTIONS <u>Current</u>	YTD	Description Aetna US Health Aetna US Health Unicare Standard 401(k) NAF Retirement ( Fed Med/ER Fed OASDI/ER  Employer contrib plan) are deposite	Care Dental Life	of the
TOTAL:							
TOTAL GROSS Current YTD	FED TAXAB	LE GROSS	TOTAL TAXES	3	TOTAL DED	UCTIONS	NET PA
Leave Plans         Prior Yr Bal         *Earn           Vacation         12.1           Sick         7.9           Comp Time         0.0           Cmp Tr Lv         0.0           Time Off         0.0	PPD Earn YTD 6.0 133.6 4.0 86.4	*Taken PPD Taken 4.0 4.0	n YTD Adjustments 137.8 90.3	End Bal 7.9 4.0 0.0 0.0 0.0	UseLose Check	NET PAY DISTRIBUTION THE STATE OF THE STATE	N
MESSAGE:							
IWAKUNI MCCS		Date: 11/06/2	2015	A	dvice No. 394	6402	

IWAKUNI MCCS
MARINE CORPS COMMUNITY
SERVICES
ATTN PERSONNEL OFFICER
FPO AP, 96310-1867

Deposit Amount:

To The Account(s) Of



	23/2015
Employee ID: Department: Job Title: Business Title: Pay Rate:  Department: Ad6919-PURCHASING/CONTRAC Allowances: Addl. Percent: Addl. Amount:	Federal WA State Married rt/a 2 0
HOURS AND EARNINGS	TAXES
	TAXES
Description   Rate   Hours   Earnings   Hours   T.2.00   Fed Withholding   Fed Withholding   Fed Withholding   Fed MED/EE   Sick Hours, No Diff   4.00   86.35   Fed OASDI/EE	<u>C</u> urrent VTD
TOTAL:	
BEFORE-TAX DEDUCTIONS AFTER-TAX DEDUCTIONS EMPLOY	YER COST OF BENEFITS
Description Actua US Health Care Tradtl Actua US Health Care Dental 401(k)  Description Unicare Supplemental Life Unicare Standard Life Opt Dependent Life 4  NAF Pension Plan 401k Loan Payback  Description Opt Description Actua US Health Care To Unicare Standard Life Unicare Standard Life Voltage Standard L	Oental
plan) are deposited towards.	s to the NAF Retirement (Group Benefit ard the collective funding level of the table to individual participant accounts.
TOTAL:	
TOTAL GROSS FED TAXABLE GROSS TOTAL TAXES TOTAL DEDUCTI	IONS NET PA!
Current YTD	
Leave Plans Prior Yr Bal *Earn PPD Earn YTD *Taken PPD Taken YTD Adjustments End Bal UseLose	NET PAY DISTRIBUTION
Vacation         12.1         6.0         127.6         11.4         133.8         6.0         Checking X           Sick         7.9         4.0         82.4         4.0         86.4         4.0           Comp Time         0.0         0.0         0.0         0.0           Time Off         0.0         0.0         0.0	XXXXX6705
TOTAL:	

IWAKUNI MCCS
MARINE CORPS COMMUNITY
SERVICES
ATTN PERSONNEL OFFICER
FPO AP, 96310-1867

Date: 10/23/2015

Advice No. 3934433

Deposit Amount:

To The Account(s) Of



IWAKUNI MCCS MARINE CORPS COMMUNITY SERVICES, ATTN PERSONNEL OFFICER FPO AP, 96310-1867	Pay C .: Pay Begin Date: Pay End Date:	IWM-Iwakuni MC 09/20/2015 10/03/2015	CS -		.ness Unit: Advice #: Advice Date:	SP145 000000003922308 10/09/2015	<del></del>
Employ Departr Job Titl Busines Pay Rai	nent: 446919-PUI le: ss Title:	RCHASING/CONTRA	С		TAX DATA: Marital Status: Allowances: Addl. Percent: Addl. Amount:	Federal Married 2	WA State n/a 0
H	OURS AND EARNING	GS				TAXES	
Description Sick Hours, No Diff Vacation Hours, No Diff Regular Hours, No Diff Admin Hours, No Diff AWOL-Absent w/o Official Leave Comp Leave Earned Holiday Hours (not worked), No Leave Without Pay Comp Leave Taken, No Diff	Current	1	Hours 82.35 122.35 178.50 2.00 8.00 64.00 22.80	Earnines	Description Fed Withholding Fed MED/EE Fed OASDI/EE	Curre	nt YTD
TOTAL:							
BEFORE-TAX DEDUCTIONS  Description  Aema US Health Care Tradtl  Aema US Health Care Dental  401(k)	YTD <u>Descriptio</u> Unicare Su Unicare Sta Opt Depen NAF Pensi 401k Loan	pplemental Life ndard Life lent Life 4 on Plan	EDUCTIONS  Current	<u>YTD</u>	Description Aetna US Healt Aetna US Healt Unicare Standar 401(k)	h Care Tradtl h Care Dental d Life t (Group Benefit)	EFITS Uzent <u>Y</u> TI
					plan) are depos	ibutions to the NAF Retireme ited toward the collective fund t attributable to individual par	ling level of the
TOTAL:	EDD TO LEG DE DE	77000	TOTAL TAN	RO.	TOTAL DE	DUCTIONS	NET PA
TOTAL GROSS	FED TAXABLE (	ROSS	TOTAL TAX	LS	TOTAL DE	DUCTIONS	RETTA
Current YTD						NEW DAY DIOTRI	DITTON
YTD           Leave Plans         Prior Yr Bal         *Earn PPI           Vacation         12.1         6	D Earn YTD *To .0 121.7 .0 78.5	ken PPD Taken YT 12.2 12: 7.8 8:		End Bal 11.4 4.0 0.0 0.0 0.0	UscLose Che	NET PAY DISTRI	BOXION

IWAKUNI MCCS
MARINE CORPS COMMUNITY
SERVICES
ATTN PERSONNEL OFFICER
FPO AP, 96310-1867

Date: 10/09/2015

Advice No. 3922308

Deposit Amount:

To The Account(s) Of



IWAKUNI MCCS MARINE CORPS COMMUNITY SER PERSONNEL OFFICER FPO AP, 96310-1867	VICES, ATTN	Pay Begin Date: 09/	M-Iwakuni MCCS 06/2015 19/2015	٠(		145 1000003910293 25/2015	
	F	170			TAX DATA:	Federal	WA Sta
	Employed Departme Job Title: Business Pay Rate:	nt: 446919-PURCHAS	ING/CONTRAC		Marital Status: Allowances: Addl. Percent: Addl. Amount:	Married 2	r
	НО	URS AND EARNINGS				TAXES	
Described.		- Current		YTD		XA0465	
Description Holiday Hours (not worked), No Regular Hours, No Diff Admin Hours, No Diff AWOL-Absent w/o Official Leave Comp Leave Earned Leave Without Pay Sick Hours, No Diff	Rate	Hours Farning 8.00 72.00	5 Hours 64.00 1,318.50 2.00 8.00	<u>Earnings</u>	<u>Description</u> Fed Withholding Fed MED/EE Fed OASDI/EE	<u>Current</u>	ут
Vacation Hours, No Diff Comp Leave Taken, No Diff			110.12				
TOTAL:							
BEFORE-TAX DEDU			FTER-TAX DEDUCTION	S	EMPLO	YER COST OF BENEFI	TŚ
Description Aetna US Health Care Tradtl Aetna US Health Care Dental 401(k)	Current	VTD Description Unicare Supplemer Unicare Standard L Opt Dependent Lift NAF Pension Plan 401k Loan Payback	ife : 4		plan) are deposited tow	Dental  Benefit)  to the NAF Retirement (Card the collective funding)	roup Benefit evel of the
TOTAL:			***		plan and are not attribu	table to individual participa	int accounts.
	L CROSS	FED TAXABLE GROSS	momit	TAXES	MODAL DEDUCE	ONG	B.2.20000 W.
Current YTD	1. GROSS	TED TAXABLE GROSS	TOTAL	TAXES	TOTAL DEDUCT	IONS	NET PA
eave Plans Prior Yr Bal	*Earn PPD	Earn YTD *Taken PP	Taken YTD Adjustn	nents End Bal	UseLose	NET PAY DISTRIBUT	ION
Vacation         12.1           Sick         7.9           Comp Time         0.0           Cmp Tr Lv         0.0	6.0 4.0 )	115.7 74.5	110.1 74.6	17.6 7.8 0.0 0.0 0.0		XXXX6705	
Time Off 0.0	•					•	

IWAKUNI MCCS
MARINE CORPS COMMUNITY
SERVICES
ATTN PERSONNEL OFFICER
FPO AP, 96310-1867

Date: 09/25/2015

Advice No. 3910293

Deposit Amount:

To The Account(s) Of



IWAKUNI MCCS MARINE CORPS COMMUNITY SERVI	CES ATTN	Pay\ p: Pay Begin Dat	IWM- le: 08/23/	Iwakuni MCCS		<del></del> -{	iness U			
PERSONNEL OFFICER FPO AP, 96310-1867	.,	Pay End Date:	09/05/				Advice #: Advice Dat	00000003898188 e: 09/11/2015		
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IWAKUNI MCCS
MARINE CORPS COMMUNITY
SERVICES
ATTN PERSONNEL OFFICER
FPO AP, 96310-1867

Date: 09/11/2015

Advice No. 3898188

Deposit Amount:

To The Account(s) Of



IWAKUNI MCCS MARINE CORPS COMMUNITY SERVICE PERSONNEL OFFICER FPO AP, 96310-1867	S, ATTN	Pay p: Pay Begin Da Pay End Date	te: 08/09/20			(	iness Un Advice #: Advice Dat	000000003886076	;	
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ATTN PERSONNEL OFFIC FPO AP, 96310-1867	CER			·					

Deposit Amount:

To The Account(s) Of

IWAKUNI MCCS MARINE CORPS COMMUNITY SERVICES, ATT PERSONNEL OFFICER FPO AP, 96310-1867	Pay C : IWM-Iwaki Pay Begin Date: 07/12/2015 Pay End Date: 07/25/2015		ness Unit: SP145 Advice #: 0000000038614 Advice Date: 07/31/2015	 147 
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Deposit Amount:				
To The Account(s) Of				

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IWAKUNI MCCS
MARINE CORPS COMMUNITY
SERVICES
ATTN PERSONNEL OFFICER
FPO AP, 96310-1867

Date: 07/17/2015

Advice No. 3848992

Deposit Amount:

To The Account(s) Of





MARINE CORPS COMMUNITY SERVICES PSC 561 BOX 1867 FPO AP 96310-0019

DSN FAX: DSN:

253-4629 COMMERCIAL: 011-81-827-79-3424 253-3424

> MCCSIWAINTINST 12630.2E 5HR 29 Oct 14

## MARINE CORPS COMMUNITY SERVICES IWAKUNI INTERNAL INSTRUCTION 12630.2E

From: Director, Marine Corps Community Services

MCCS Iwakuni NAF/GS Employees To:

Subj: ABSENCE AND LEAVE

Ref: (a) MCO P12000.11A

(b) U.S. Office of Personnel Management Website

Encl: (1) Application for Leave Form, OPM-71

- Purpose. To publish policy and procedures on employee notification to supervisor of absence from work and for requesting leave as provided in the references.
- Cancellation. Marine Corps Community Services Internal Instruction 12630.2D.
- This instruction is applicable to all Marine Corps Community Services (MCCS) Non-Appropriated Fund (NAF) and Appropriated Fund (GS) employees.
- Information. The need for an employee to be at their designated work site at the scheduled start time is critical in providing good service to our customers for all the MCCS divisions and activities. In order for a supervisor to quickly adjust to the absence of an employee, it is the responsibility of the employee to notify the supervisor of their inability to report to work as soon as possible. A supervisor must also have the ability to prepare work schedules in advance to compensate for an employee's request for leave.

## Action 5.

If an employee is unable to report for work at the scheduled start time due to illness or other unforeseen circumstances, it is the employee's responsibility to notify the supervisor as early as possible of their inability to report for

- work. The employee must notify the supervisor no later than the beginning of their scheduled shift.
- The supervisor or a higher management official is the only individual who can approve the leave of an employee. An employee cannot assume that their leave is approved just because of calling in and speaking to another employee. Employees are required to call their immediate supervisor and leave a voicemail if they are unable to speak to the supervisor. Additionally, employees are required to continue their attempts to call in by contacting the supervisors up their chain of command (up to the Chief of their Division) and leaving a voicemail each time the attempt is made. Notifying the supervisor via e-mail is acceptable; however, it is considered approved only when the employee received a response from the supervisor permitting their leave of absence. Failure of the employee to utilize this process will cause the employee to be in an Absence Without Leave status and the employee could be subject to disciplinary action.
- c. Employees must notify the supervisor each day of an absence unless a doctor's certificate has been obtained and provided to the supervisor. Employees are required to complete the Application for Leave, enclosure (1), immediately upon their return to work.
- d. Sick leave absences in excess of 3 consecutive working days will only be granted when supported by administratively acceptable evidence to include a certified letter or note from the treating physician that excuses absences from work.
- e. When returning to work from a sick leave status in excess of 3 working days, employees are required to receive a return to work authorization from the treating physician prior to returning to work. The authorization must be provided immediately to the supervisor upon returning to work. Any requests for reasonable accommodations or limited duty are required to be documented on this authorization.
- f. Per reference (b), a pregnant employee who must be absent from work at some point before giving birth for her own health or that of her unborn child is entitled to use sick leave. According to the definition of serious health condition, any period of incapacity due to pregnancy or childbirth, or for prenatal care, is considered a serious health condition, even if

the employee does not receive active treatment from a health care provider during the period of incapacity or the period of incapacity does not last more than 3 consecutive calendar days. Sick leave may be used for medical examinations and during the period of incapacitation for delivery and recuperation. Once the period of incapacitation is over, there is no entitlement to use sick leave. An employee may not use sick leave to voluntarily be absent from work to bond with a healthy newborn. There is no provision in law or regulation that permits the use of sick leave to care for a healthy newborn, bond with a healthy child, or for other child care responsibilities.

- g. If the supervisor suspects an employee is abusing their sick leave benefit, the supervisor may place the employee on a Letter of Requirement after providing documentation to Human Resources.
- h. If an employee becomes ill while at work, the employee will complete enclosure (1) before leaving the work site, if practical or as soon as returning to work.
- An employee is entitled to use sick leave if health authorities or a health care provider determine that the employee's presence on the job would jeopardize the health of others because of exposure to a communicable disease. of sick leave would be appropriate in these circumstances even if the employee is not sick but would be limited to circumstances where exposure alone would jeopardize the health of others and would only arise in cases of serious communicable diseases, such as communicable diseases where Federal isolation and quarantine are authorized, which currently includes: cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, Severe Acute Respiratory Syndrome (SARS), and influenza that causes or has the potential to cause a pandemic. For more information, visit http://www.cdc.gov which provides an illustrative, but not exhaustive, list of the types of serious communicable diseases where exposure alone would jeopardize the health of others.
- j. Annual leave should be planned as far in advance as possible, especially if the leave time is in excess of 3 working days. The supervisor should approve and schedule the annual leave when the workload permits, and whenever possible, at the convenience of the employee.

- k. A minimum of 2 weeks is required for employees to submit enclosure (1) for any leave with the exception of sick leave for approval to the supervisor. If the annual leave must be denied due to workload requirements, a justification by the supervisor will be given to the employee and a suggested alternate time for taking the annual leave will be provided.
- 1. When two employees request annual leave for the same time period, and if only one employee can be allowed leave due to workload requirements, approval will be given to the employee who submitted the request first. The supervisor should suggest an alternate time for taking leave to the other employee.
- 6. Effective Date. This instruction is effective upon receipt.



1. Name (Lost, first, middle) 2. E					Employee or Social Security Number		
3. Organization						·	
	Ту	pe of Leave/A	bsence			5. Family and Medical Leave	
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MARINE CORPS COMMUNITY SERVICES PSC 561 BOX 1867 FPO AP 96310-0019

FAX: COMMERCIAL: DSN: 011-81-827-79-4057 011-81-827-79-3030

253-3030

12710 5SUP 13 MAR 15

From: Purchasing and

Contracting

To:

, Purchasing and

Contracting

Subj: LETTER OF WARNING

Ref:

- (a) MCO P12000.11A
- (b) MCCSINTINST 12630.2E dtd 29 Oct 14
- 1. This letter is to notify you of your unacceptable conduct. This action is based on the following fact:
  - a. Improper call off on 2 March, 2015
- 2. As the Contract Administrator, you are expected to conduct yourself with a higher level of professionalism. Your failure to properly notify your supervisor when calling off work has a negative impact on the workplace and morale of the Purchasing and Contracting Department. Your actions affect the mission by hindering the daily business operations of the office resulting in cancellation of client appointments and rescheduling of staff to cover your absence.
- 3. You are hereby placed on notice that this type of conduct will not be tolerated. Further acts of misconduct could result in formal disciplinary action. Violations discussed in this letter will not be counted as offenses, but could be cited in any future disciplinary action.
- 4. This letter will not be placed in your Official Personnel Folder, but will be retained by the undersigned. You are reminded that in accordance with reference (a), a letter of warning is not a disciplinary action and is neither grievable nor appealable.

5. You are requested to acknowledge receipt of this letter by signing in the appropriate space on the copy provided.

13MAR45

Copy to: Human Resources



MARINE CORPS COMMUNITY SERVICES PSC 561 BOX 1867 FPO AP 96310-0019

FAX: COMMERCIAL: DSN: 011-81-827-79-4057 011-81-827-79-3030

253-3030

12710 5PC 25 MAR 15

From:

Chief of Support, Marine Corps Community Services

To:

Subj: LETTER OF WARNING

Ref:

(a) MCO P12000.11A

(b) MCCSINTINST 12630.2E dtd 29 Oct 14

1. This letter is to notify you of your unacceptable conduct. This action is based on the following facts:

- a. Failure to follow a direct order
- b. Failure to carry out policies and procedures
- 2. As a supervisor within MCCS, you are expected to follow direct orders and to carry out policies and procedures. When you are called upon to take action or to ensure proper execution of policies and procedures, you are expected to do so. Your failure to properly account for your subordinate employee's time, especially after I, your supervisor provided direction to do so, is a serious offense, which will not be tolerated. Your actions affect trust and confidence that I, as your supervisor, place in you. Moving forward, please understand the importance of proper time keeping.
- 3. You are hereby placed on notice that this type of misconduct will not be tolerated. Further acts of misconduct could result in formal disciplinary action. Violations discussed in this letter will not be counted as offenses, but could be cited in any future disciplinary action.
- 4. This letter will not be placed in your Official Personnel Folder, but will be retained by the undersigned and Human Resources. You are reminded that in accordance with reference (a), a letter of warning is not a disciplinary action and is neither grievable nor appealable.
- 5. You are requested to acknowledge receipt of this letter by signing in the appropriate space on the copy provided.

ADDRESSEE'S SIGNATURE

25 MAR 15

DATE

Copy to:

Human Resources

## December 2015

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
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#### December 2015 Translation Log

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	Arrives to work @ 0840	3	Sick leave, did not show	5
6	Arrives 0840 Leaves 1130 for lunch. Never came back.	8 off-Leave	off. left@1640 wl restof THA employ.	off. 1500 left@1500 ees. for day.	11 Doctor app/ Sick leave. Did not come in at all.	12
13	14 Ductor app in morning	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

### November 2015 Translation Log

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	on LV. left @ 0930 for dictor app. Didn return to work	3 1	entire day, Sick Leave	5	6	7
8	9	10	11 Veterans Day	entire day, Sick leave	13	14
15	16	17	18	10	left early afternoon for MCBall, LV	21
22	23	24 @ 0930	25 Sickleave, offentire day	26	did not show to work	28
29	30					

## NOVMBER 2015

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1	2 9時半から医者、も どってこない。上司 は有給	3	4. 病欠	5	6	7
8	9	10	11 祭日	12 病欠	† <b>13</b>	14
15	16	17 病欠	18 病欠	19	20 マリーンボール 早退	21
22	23	24 30 分遅刻	25 病欠	26 祭日	27 休暇	28
29	30 病欠					
				; ; ;	:	

Kudingel Nov 15 0800~1/10 Appointment 0800 - 1700 S/L

ENCLOSURE (23)

# May 2015

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2
4	5	6	7	8	9
11	12	13	14	15	16
18	19	20	21	22	23 ·
25	26	27	28	29 Contractor meeting @ 1400. No show; refer	30
				to timesheet.	
	11 18	4 5 11 12 18 19	4 5 6 11 12 13 18 19 20	4 5 6 7 11 12 13 14 18 19 20 21	4     5     6     7     8       11     12     13     14     15       18     19     20     21     22